MEDICAID ELIGIBILITY HANDBOOK

RELEASE 05-01, JANUARY 11, 2005

1 GENERAL PROGRAM REQUIREMENTS

1.1 GENERAL MEDICAID INFO

1.1.1 DEFINITIONS

Medicaid, also known as Medical Assistance, MA, and Title 19, is a state/federal program that helps low income people pay their medical bills. A person is eligible if s/he meets all non-financial and financial requirements.

Note: An individual could be both AFDC related and EBD related. An example would be a disabled child or disabled caretaker. This type of individual would usually first be tested for AFDC related (Family) Medicaid and if they failed the family Medicaid tests, they would then be tested for EBD MA (1.1.1.2).

1.1.1.1 Family MA

Family MA is for:

1. Individuals under age 19.
2. Pregnant women.
3. Parents and caretaker relatives of children under age 19.

The following are types of Family MA:

1. AFDC-MA.
2. AFDC-Related MA.
3. Healthy Start (5.2).
4. BadgerCare (5.7).
5. Foster Care (5.3).

1.1.1.2 EBD MA

EBD MA is elderly, blind, disabled MA. The client must be:

1. 65 or older, or
2. Blind or disabled as determined by the Disability Determination Bureau (DDB).

There are special rules for residents of an institution for mental disease (IMD) under age 21 (5.8.1.1).

The following are types of EBD MA:

1. Institutional MA (5.8).
2. Non-institutional EBD MA.
3. Community Waivers (5.9).
4. Medicaid Purchase Plan (MAPP) (5.12).
5. 1619 (5.11.5).
6. Katie Beckett (5.11.6).
7. Medicare beneficiaries (5.14).
8. SSI.

1.1.1.3 Special Status MA

Several categories of MA do not fit into either the Family or EBD categories of MA. Qualifications are unique for each category of MA, and the amount of benefits may vary. The following are types of Special Status MA:

1. TB-Related (5.11.7).
2. Adoption Assistance.
3. Wisconsin Well Woman Medicaid (5.17).
4. Emergency Services (3.2.3).
5. Family Planning Waiver (5.15).

This page last updated in Release Number: 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

1.1.2 NON-FINANCIAL

These requirements apply to all types of MA, unless specifically stated otherwise. The client must:

1. Provide a Social Security Number (SSN) or be willing to apply for one.

   If the caretaker is unwilling to provide or apply for the SSN of a minor or dependent 18-year-old, the person who does not have the SSN is ineligible.

   Do not require an SSN for:

   a. Continuously eligible newborns.

   b. Pre-adoptive infants living in a foster home.

   c. Unqualified aliens receiving emergency services.

2. Be a Wisconsin resident (3.1).

3. Be a U.S. citizen or qualified alien (3.2). This does not apply to aliens receiving emergency services (3.2.3).

4. Be living in the household.

   A household is all the people living in or temporarily absent (3.5.6) from the same residence. In addition to regular household members, include:

   a. Huber law prisoners who are released from jail to attend to the needs of their families.

   b. People in a community residential confinement program. The Department of Corrections (DOC) electronically monitors them.

   c. Those in military service. Answer all non-financial eligibility questions as if s/he were in the home. Do not include him/her in the MA fiscal test group (FTG) or count his/her income or assets.

Do not include the following in the household:

a. Inmates of a public institution.

b. If an inmate is a prisoner in jail, prison, or other correctional institution, but resides outside of the public correctional institution for more than 24 hours at any one time, do not consider him/her an inmate for that time period (3.1.9). S/he can qualify for MA during that time period if s/he meets all other eligibility criteria.

c. SSI recipients.

   SSI recipients are actually receiving SSI benefits, including MA, or would be receiving benefits except for recoupment.

   A client is not an SSI recipient if s/he is eligible for SSI but has not received benefits.

5. Provide information on health insurance coverage (6.3.3.2).

6. Sign over to the state their rights to payments from a third party for their medical expenses (3.3.1).

7. Cooperate with Medical Support Liability (MSL) (3.3)

Deny or terminate eligibility for caretakers who refuse to cooperate, unless there is good cause. This is applicable to anyone who is applying for Family MA or EBD MA. The Child Support Agency (CSA) will inform you in writing of those who are not cooperating.

Example: Liz, a disabled parent, is applying for MA for her and her son, Steve. She refuses to cooperate with the child support agency in the pursuit of medical support liability. Liz meets all other non-financial and financial criteria for Family MA and EBD MA.

Liz is not eligible for EBD MA or Family MA, because she will not cooperate with obtaining medical support. Even though Liz refuses to cooperate with obtaining medical support, Steve remains eligible for MA.

Do not sanction minors, dependent 18 year olds, and pregnant women until two months after the pregnancy ends.

8. Cooperate with verification requests when information is deemed questionable (1.2).

9. Meet any additional criteria that is specific to the subprogram of MA that s/he is being tested for. Any non-financial criteria specific to a particular subprogram of MA will be listed in the chapter relating to that subprogram.

10. Not be an inmate of a public institution (see 3.1.9).

1.1.2.1 Additional Family Requirements

In addition to the non-financial requirements listed in 1.1.2, a client applying for Family MA must not be on strike (3.4). Do not sanction anyone on strike who is pregnant, a minor, over age 65, blind or disabled, on a MA extension or a Family Planning Waiver applicant/recipient.

This page last updated in Release Number: 05-01
Release Date: 01/11/05
Effective Date: 01/11/05

1.1.3 FINANCIAL

See 8.1.5 for EBD asset limits. There is no asset test for any Family MA subprogram. See 5.11.7.2 for TB-Related asset limits. See 1.1.3.1.2 to determine Medicaid eligibility for disabled minors that fail Family Medicaid financial tests.

1.1.3.1 Assets

Use the EBD Related Determination worksheet when doing manual eligibility determinations for non institutionalized EBD Medicaid applicants and recipients. The EBD fiscal group's assets must be within the appropriate categorically needy or medically needy asset limit before any member of that group can qualify for Medicaid. EBD fiscal groups who have assets in excess of the appropriate EBD medically needy asset limit are ineligible for Medicaid.

1.1.3.1.1 EBD Fiscal Group

An EBD fiscal group includes the individual who is non financially eligible for Medicaid and anyone who lives with them, who is legally responsible for them. Spouses who live together are in each other's fiscal group. This means that the income and assets of both spouses are counted when determining Medicaid eligibility for either or both spouses. The fiscal group size for this situation/living arrangement is two.

There are some exceptions to this concept. A blind or disabled minor (or dependent 18 year old), living with their parents would be a one person fiscal group. Special instructions for deeming parental income and assets to the disabled minor are described in (1.1.3.1.2).

Another exception to the fiscal group policy involves SSI recipients. If one spouse is applying for EBD Medicaid and the other spouse is an SSI recipient, the SSI recipient spouse is not included in the other spouse's fiscal group. For this situation you would again have a one person fiscal group when determining the Medicaid eligibility of the non-SSI spouse.

An individual living in a medical institution for 30 or more consecutive days would be a one person fiscal group. If the institutionalized person is married, refer to chapter 5.10 for special instructions regarding spousal impoverishment procedures.

1.1.3.1.2 Special Financial Tests for Disabled Minors

A blind or disabled minor (or dependent 18 year old) would have their Medicaid eligibility determined according to the following special procedures when the disabled minor fails Family Medicaid financial tests. This process essentially deems parental income and assets to the disabled minor. The deemed parental income and assets are added to the disabled minor’s income and assets when determining the disabled minor’s financial eligibility for EBD Medicaid.

The disabled minor is a separate fiscal group of one. A child who is an SSI recipient is not considered to be a household member and therefore not included in any of the following procedures.

An ineligible child in this section is a minor child who is neither disabled nor blind.

An eligible child in this section is a minor child who is disabled or blind or both.

Calculate the countable assets of all eligible children and their parents in the household. Count all of the person’s assets except those that are exempt or unavailable. See Chapter 4.5. Before deeming the countable assets of the parent/parents to the eligible children in the household disregard $2000 of these countable assets if there is one parent in the household and $3000 if there are two parents in the household.

Example1 : A single parent with a disabled minor owns $4500 in nonexempt assets. $2500 of that asset would be deemed to the disabled minor when determining the minor's Medicaid eligibility.

Example 2: A parent and his/her spouse own $4500 in non-exempt assets. The parent has a disabled minor. $1500 of the parent's and the spouse's assets would be deemed to the disabled minor when determining the minor's Medicaid eligibility.

Calculate the countable income of everyone in the Household using the following 7 steps. Count all of the person’s income except that which is exempt or unavailable. See Chapter 4.1.

1. Divide parental countable assets equally among the eligible children in the household. Add each child's assets to his or her share of parental assets.

   Enter the total on line 4 of the EBD-Related Determination worksheet (WKST 06).

   If the child's asset amount is greater than the medically needy asset limit, he or she does not pass the asset test and cannot receive Medicaid.

   Go to #2, if any child has passed the asset test.

2. For each ineligible child in the household:

   a. Subtract the ineligible child's unearned & earned income from the EBD Deeming Amount to an Ineligible Minor (8.1.5.1).

b. The remainder is the amount to be allocated to the ineligible child from parental gross unearned income.

   If there is not enough parental unearned income, allocate the rest from parental gross earned income.

   Go to #3.

3. Subtract $20, the general income exclusion, from any remaining parental unearned income.

   If there is not enough unearned income to subtract the full $20, subtract the rest of the $20 from parental earned income.

   Go to #4.

4. Subtract $65 & 1/2 from the remaining parental earned income.

   Go to # 5.

5. Add:

a. Remaining parental unearned income resulting from step 03, and

   b. Remaining parental earned income resulting from step 04

   Go to #6.

6. From the total parent income resulting from #5, subtract:

   a. The Parental Living Allowance (8.1.5.1) for a couple if both parents (or one parent and his/her spouse) live in the household; or

   b. The Parental Living Allowance (8.1.5.1) for an individual if only one parent lives in the household.

   The remainder is the total parental income to be deemed to the eligible child(ren).

   Go to #7

7. Divide the parental deemed income equally among the eligible children. Use the EBD-Related Determination worksheet (WKST 06) to calculate each child's Medicaid eligibility.

Example 1: Mr. and Mrs. Darwin have two children. Matthew, eight years old, is disabled, and is the eligible child. Jenny, 10 years old, is the ineligible child. Neither child has income. The Darwins have no assets and no unearned income. Parental earned income is $2,100 a month. Parents' earned income $2,100.00 EBD deeming amount to an ineligible minor -289.50

Remaining earned income $1,810.50
General income exclusion -20.00
Remainder $1,790.50
Earned income exclusion -65.00

Remainder $1,725.50
1/2 remaining earned income -869.00

Remaining earned income $ 856.50
Parental living allowance -869.00

Income deemed to eligible child $ 40.00

Example 2: Lawrence has three children. One is disabled. None has any income. Lawrence has no assets. His monthly income is $1750 earned, $290 unearned.

Lawrence's unearned income $ 290.00

EBD Deeming Amount for 2 ineligible minors -579.00
Excess allocation $ -289.00
Lawrence's earned income $1,750.00
Excess allocation $-289.00

Lawrence's remaining earned income $1,461.00
General income exclusion -20.00

Remainder $1,441.00
Earned income exclusion -65.00
Remainder $1,376.00
1/2 remaining earned income -$688

Remaining earned income $ -688
Parental living allowance $ -579.00

Income deemed to eligible child $ 109

1.1.3.2 Income

See 8.1.5 for EBD income limits. See 8.1.6 for all other MA income limits. Chapters for each type of MA explain how to determine the income that you compare to the income limits.

See (8.1.5.1) for TB-Related income limits.

Use the AFDC Related Determination Worksheet (WKT 14) for Manual Family Medicaid Financial Determinations.

1.1.3.3 EBD Related Test

When doing manual EBD income eligibility determinations, use the EBD Related Determination worksheet. Apply the income disregards in the order in which they appear on the worksheet. The 65 & ½ earned income disregard and $20.00 SSI general income disregard are applied to the fiscal group's income. They are not applied separately to each individual fiscal group member's income. Special Exempt Income is also an allowable income deduction and a list of Special Exempt Income types can be found in chapter 4.1.3.2.

The EBD categorically needy income limit consists of two components; an income amount plus a shelter/ utility amount. The EBD fiscal group's total actual shelter, fuel, and utility expenses are compared to a maximum allowance that is found in chapter 8.1.5. The actual shelter/utility costs or the shelter/utility maximum, whichever is less, is added to the categorically needy income amount (chapter 8.1.5), and this total becomes the EBD categorically needy income limit. A fiscal group with income that does not exceed the categorically needy income limit passes the Medicaid EBD categorically needy income test.

If an EBD related fiscal group's income exceeds the categorically needy income limit, their income is then compared to a medically needy limit, which is found in chapter 8.1.5. If the fiscal group's income is between the categorically needy limit and the medically needy limit, the group passes the Medicaid EBD medically needy income test.

If an EBD fiscal group fails the medically needy income test because their net income exceeds the medically needy income limit, they can still qualify for Medicaid if they can meet a Medicaid Deductible. Refer to chapter 4.9. for more information about Medicaid Deductibles and to chapter 4.9.5 for instructions on how to calculate a Medicaid Deductible.

This page last updated in Release Number: 05-01
Release Date: 01/11/05
Effective Date: 01/01/05

1.2 VERIFICATION

1.2.1 DEFINITION

Verification is part of determining eligibility. To verify means to establish the accuracy of verbal or written statements made about a group's circumstances. Documentation is a method by which you accomplish verification.

You will ask the questions needed to determine eligibility, but only need to verify mandatory and questionable items.

If the client is applying for other programs of assistance or if you are looking for sources of verification, see the IMM, Chapter I, Part C.

1.2.1.1 Documentation

Case comments in CARES provide documentation. Your notes report what happened in collateral contacts, viewing documents, home visits, etc. Include enough data to describe the nature and source of information if follow up is needed. There is no requirement to photocopy and file verification items.

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

1.2.2 general rules

1. Apply these verification instructions only to Medicaid (MA), including Family Care Non-MA (5.13.1) and Medicare Beneficiaries (5.14.1).

2. Only verify items necessary to determine eligibility for MA.

3. If an item is not mandatory or questionable, do not verify it.

4. Do not over-verify. Requiring excessive pieces of evidence for any one item is over-verification. If you have all the verification you need, do not continue to require additional verification.

5. Do not verify information already verified unless you believe the information is fraudulent or differs from more recent information. If you suspect fraud exists, determine if you should make a referral for fraud or front-end verification (1.2.6). Fraud in other programs of assistance does not affect MA verification.

6. Do not exclusively require a particular type of verification when various types are possible.

7. Do not target special groups or persons on the basis of race, religion, national origin or migrant status for special verification requirements.

8. Do not harass the client or violate his/her privacy, personal dignity, or constitutional rights. Respect personal rights.

9. If a client chooses to provide you missing but needed verification directly, do not require him/her to sign a release form. If s/he provides you with the required verification without a release and it is sufficient to establish eligibility, accept the verification.

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

1.2.3 MANDATORY VERIFICATION ITEMS

Verify the following mandatory items:

1. SSN (1.2.3.1).
2. Alien Status (3.2.2.).
3. Pregnancy, if eligibility is based on the pregnancy (5.2.1).
4. Disability and Incapacitation (3.6.1).
5. Assets, for the Elderly, Blind and Disabled (EBD) (4.5.1).
6. Divestment, for EBD (4.7.1).
7. Medical Expenses, for deductibles only (4.9.8).
8. Documentation for Power of Attorney and Guardianship (1.2.3.7)
9. Migrant workers eligibility in another state (5.11.8.1), if applicable.
10. Physician certification (verbally or in writing) that the person is likely to return to the home or apartment with-in 6 months for institutionalized persons maintaining a home or property (4.1.3.1) and is entitled to a home maintenance allowance.

Accept self declaration for all other items, unless you document them as questionable.

1.2.3.1 Social Security Number

Social Security Numbers (SSNs) need to be furnished for household members requesting MA, but are not required from non-applicants. SSNs should be recorded in CARES if obtained voluntarily from the client, or if the information is available through other information sources (e.g. bank statement).

An applicant does not need to provide a document or social security card. S/he only needs to provide a number, which is verified through the CARES SSN validation process.

If the SSN validation process returns a mismatch record, then the client must provide the social security card or another official government document with the SSN displayed. If an applicant does not yet have a SSN s/he must be willing to apply for one.

Verify the SSN only once.

1.2.3.1.1 Newborns

Assist the client in applying for an SSN for any group member who doesn’t have one (IMM, Ch. I, Part C).

Do not deny benefits pending issuance of a SSN if you have any documentation that an SSN application was made. A parent of a newborn may begin a SSN application on the newborn’s behalf while still in the hospital. Verify this through the Birth Record Query.

Do not require an SSN to be furnished or applied for on behalf of a newborn determined continuously eligible (5.2.5) for MA. Accept the mother's statement about the existence and residence of the newborn.

1.2.3.1.2 Emergency Services

Do not verify SSNs of clients who receive emergency services only. (3.2.3)

1.2.3.2 Alien Status

A client who indicates s/he is not a citizen must provide an official government document that lists his/her alien registration number. Verify the individual's alien status by using the Systematic Alien Verification for Entitlement (SAVE) system.

An alien that presents documentation of his/her alien status and meets all other eligibility criteria is presumptively eligible. Begin benefits and determine, through SAVE, that s/he is in a satisfactory immigration status.

Verification of alien status is not needed if the person already provided proof when s/he applied for an SSN.

Do not re-verify alien status unless the client reports a change in citizenship or alien status.

1.2.3.3 Pregnancy

If a woman wants to be considered pregnant for a MA eligibility determination, documentation from a health care professional attesting to the pregnancy is required. Fetus count and the pregnancy end date are not mandatory verification items.

1.2.3.4 Disability

For any person who wants to be considered disabled for MA, including the Medicaid Purchase Plan (MAPP), DDB must complete a disability determination (3.6.1). There is no need to re-verify after the initial determination. Disability reviews are scheduled by DDB and they will send any new information to you. Receipt of SSI or OASDI benefits is verification of disability.

1.2.3.5 Assets

Verification of assets is mandatory for clients requesting the following MA subprograms:

1. EBD (categorically and medically needy).
2. EBD Special Status (503, Disabled Adult Child, Widow/widowers).

3. Medicaid Purchase Plan (MAPP).
4. Institutional MA.
5. Community Waivers, including PACE and Partnership.
6. Family Care.
7. Medicare Premium Assistance Programs.

Also verify assets of community spouses for community waivers, institutional MA and Family Care non-MA. If reported assets exceed the asset limit, do not pursue verification.

Do not verify exempt assets.

Example: An EBD MA client's burial plot is not counted in determining his/her MA eligibility. Do not require verification of its value in determining the group's MA eligibility.

You do not need to verify cash on hand.

See IMM, Chapter 1, Part C for asset verification sources.

1.2.3.5.1 Divestment

Verify if a client or spouse has divested assets when determining eligibility for institutional MA and community waivers (4.7.1).

1.2.3.6 Medical Expenses

Verify medical expenses if they are used to meet a deductible. Verify the expense and date of service.

1.2.3.7 Power of Attorney and Guardianship

Verify power of attorney and any guardianship type as specified by the court. Ask for any documentation regarding durable power of attorney or court-ordered guardianship. For applications and other relevant applicant information, refer to Power of Attorney as "Power of Attorney for Finances".

The ESA must determine the guardianship type specified by the court. Only the person designated as "guardian of the estate," "guardian of the person and estate," or "guardian in general" may attest to the accuracy of the information on the application form and sign it. Do not require a "conservator" or "guardian of the person" to sign the application form.

1.2.4 QUESTIONABLE ITEMS

Information is questionable when:

1. There are inconsistencies in the group's oral or written statements.

2. There are inconsistencies between the group's claims and collateral contacts, documents, or prior records.

3. The client or his/her representative is unsure of the accuracy of his/her own statements.

4. The client has been convicted of MA recipient fraud or has legally acknowledged his/her guilt of recipient fraud. Do not require a client to provide verification for the sole reason that they have acknowledged or been convicted of fraud in any other public assistance or employment program.

5. The client is a minor who reports that s/he is living alone. This does not apply to minors applying solely for FPW.

1.2.4.1 Tuberculosis

See 5.11.7.1 for appropriate verification items if information provided is questionable.

1.2.4.2 Farm and Self-employment Income

See 4.2.6 for appropriate verification items if information provided is questionable.

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

1.2.5 Client Responsibility

1.2.5.1 Assist the client

The ES worker has a responsibility to use all available data exchanges to verify information, but the client has primary responsibility for providing verification. The client must likewise resolve questionable information. Do not deny eligibility when the client does not have the ability to produce verification.

Assist the client in obtaining verification if s/he has difficulty in obtaining it.

Use the best information available to process the application or change within the time limit and issue benefits when the following two conditions exist:

1. The client does not have the power to produce verification, and
2. Information is not obtainable timely even with your assistance.

In this situation, seek verification later. When you have received the verification, you may need to adjust or recoup benefits based on the new information. Explain this to the client when requesting verification.

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

1.2.6 Front End verification

Front-End verification (FEV) is intensive verification of a case by a special unit or worker. Refer a group for FEV only when it's characteristics meet a designated profile. See IMM, Ch. I, Part E.

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

1.2.7 Wen to verify

Verify mandatory and questionable items at application, review, person addition or deletion, or when there is a change in circumstance that affects eligibility or benefit level. Do not reverify one time only verification items.

1.2.7.1 Application and Review

The time period for processing an application for MA is 30 days. Advise the applicant of the specific verifications required within the 30 day processing time. Give the applicant at least ten days to provide any necessary verification.

Do not deny the group for failure to provide the required verification until the:

1. 11th day after requesting verification, or
2. 31st day of the application or review processing period, whichever is later.

If you request verification more than ten days prior to the 30th day you must still allow the applicant the full 30 days to provide the required verification.

1.2.7.2 Changes

Advise the recipient of the specific verification required and allow a minimum of ten days to provide it.

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

1.2.8 ACTIONS

1.2.8.1 Positive Actions

Begin or continue benefits when:

1. The client provides requested verification within the specified time limits and is otherwise eligible.

2. Requested verification is mandatory, but the client does not have the power to produce the verification and s/he is otherwise eligible.

1.2.8.2 Delay

Notify the client of a processing delay when:

1. Verification is needed, and
2. S/he has the power to produce the verification, and
3. The minimum time period allowed for producing the verification has not passed.

CARES provides a verification checklist, to notify the client of the reason for the delay, the specific verification required, and the date the verification is due.

1.2.8.3 Negative Actions

Deny or reduce benefits when all of the following are true:

1. The client has the power to produce the verification.
2. The time allowed to produce the verification has passed.
3. The client has been given adequate notice of the verification required.
4. You need the requested verification to determine current eligibility. Do not deny current eligibility because a client does not verify some past circumstance not affecting current eligibility.

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

1.2.9 RELEASE OF INFORMATION

You need someone's written release to get information from a verification source only when the source requires it.

When a source requires a written release:

1. Explain the requirement to the client.

2. Ask the client, his/her spouse, or another appropriate adult in the household to sign the necessary release form(s). The form may be:

   a. The CARES-generated or alternate pre-printed application forms.

   b. A Confidential Information Release Authorization, HFS-9.

Deny, discontinue or reduce benefits only when:

1. No appropriate person will sign the release form, and
2. The missing verification is necessary to determine eligibility, and
3. The client is unwilling or unable to provide the verification directly, and
4. The source requires a release, and
5. The release is the only way you can obtain the verification.

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

1.2.10 Verification resources

Workers can access many sources of information through data exchanges such as income, Social Security (SS), Unemployment Compensation (UC), and birth records. See the CARES Guide, Chapter 1X for instructions. See the IM Manual, Ch. 1, Part D, 4.0.0 for instructions on the SAVE (Alien Verification) System.

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

2 APPLICATIONS AND REVIEWS

2.1 APPLICATION INTRODUCTION

2.1.1 APPLICATION INTRODUCTION

Encourage anyone who expresses interest in applying to file an application the same day. When an application is requested, mail the application or schedule a telephone or face-to-face interview the same day. Provide any instruction and/or materials needed to complete the application process. Provide a Notice of Assignment: Child Support, Family Support, Maintenance and Medical Support form (DWSW 2477) and Good Cause Claim form (DWSW 2018) to each client with children that is applying for Medicaid (MA) or to anyone that requests either of these.

Make applications available, upon request, to those groups and persons involved in outreach efforts.

Note: It is possible to apply for Medicaid on behalf of a deceased person. If the date of death is within 3 months before the application date, determine the deceased person's eligibility as if s/he were alive. If the date of death is earlier than 3 months before the application date, s/he is not eligible.

2.1.1.1 Right to Apply

Allow any person to apply for MA, including minors. An authorized representative may apply on a person’s behalf if s/he requests, is incapacitated, or incompetent.

Contact by a client’s representative before s/he submits a signed application form is only an inquiry about assistance.

2.1.1.2 Affirmative Action and Civil Rights

The Rehabilitation Act of 1973 requires a person with impaired sensory, manual, or speaking skills have an opportunity to participate in programs equivalent to those afforded non-disabled persons.

Notify clients during intake that assistance is available to assure effective communication. This includes certified interpreters for deaf persons and translators for non-English speaking persons. See the Wisconsin Medicaid Eligibility and Benefits brochure (PHC 10025).

The Civil Rights Act of 1964 requires that applicants for public assistance have an equal opportunity to participate regardless of race, color, or national origin.

This page last updated in Release Number: 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

2.1.2 Choice of Application

Inform the client that the following three application and review options are available for any client who is applying for MA only:

1. Face-to-Face Interview.
2. Mail-In.
3. Telephone Interview.

If the client chooses the mail-in or telephone method of application, inform him/her that this effectively eliminates a choice of W-2, Child Care (CC), Caretaker Supplement (CTS) , and Food Stamps (FS) eligibility for them as part of this application. Complete Client Registration at the time of the initial contact with the client.

When an individual chooses the MA only telephone or mail-in application method, a written and signed form stating they are 'not requesting' FS, CC, CTS, or W-2 is not required, as long as the client is completing a telephone application or using the Medicaid Elderly, Blind, Disabled Application (HCF 10101) or the Wisconsin Medicaid/BadgerCare Family Application form (HCF 10100).

Once a client has chosen a method of application, do not require the client to use that method for any subsequent reviews. The client may choose any of the three methods listed above at each review of eligibility.

This page last updated in Release Number : 03-01
Release Date: 01/01/03
Effective Date: 01/01/03

2.1.3 Valid Application

A valid application for a subprogram of MA must include the client's:

1. Name, and
2. Address, and
3. Signature in the Rights and Responsibilities section of a MA application.

The date the application is received by the Economic Support Agency (ESA) with the client's name, address and signature is the filing date. The 30-day processing timeframe begins on the filing date.

However, non-financial and financial information is needed to determine eligibility. Collect any other necessary information before approving or denying the application.

2.1.3.1 Assistance in Applying

The client may be assisted by any person s/he chooses in completing an application. Any person that s/he chooses to apply on his/her behalf must be designated as an authorized representative (IMM, Ch. I, Part A, 18.3.0).

The client may have a guardian or conservator (IMM, Ch. I, Part A, 19.0.0) complete the application for him/her. Ensure that any person claiming to be a guardian or conservator is authorized to apply on the client's behalf.

Assist the client in completing the application if s/he needs assistance. When a client contacts the incorrect agency for him/her, redirect him/her to the correct agency immediately. If the contact is an application form received by mail or fax, send the application form to the correct location within the same day or the next working day after receipt. Remember, if the application is faxed the same day the application is received, the filing date is preserved.

2.1.3.1.1 Durable Power of Attorney

A client's Durable Power of Attorney may appoint an authorized representative (2.1.3.5.1) for purposes of making a Medicaid application if authorized on the power of attorney form. The Durable Power of Attorney Form will specify what authority is granted.

The appointment of a Durable Power of Attorney does not prevent a client from filing his/her own application for Medicaid nor does it prevent the client from granting authority to someone else, to apply for public assistance on his/her behalf.

2.1.3.2 Residence

The client must apply in the county in which s/he resides. A client who resides in a nursing home is a resident of the county in which the nursing home resides.

The client's county of residence at the time of admission must receive and process applications for persons in these state institutions:

1. Northern, Central, and Southern Centers.
2. Winnebago and Mendota Mental Health Institutes.
3. The University of Wisconsin Hospital.

Waupaca County receives and processes all applications and reviews for residents of the Wisconsin Veterans Home at King, regardless of the county of residence.

2.1.3.2.1 Intercounty Placements

When a county 51.42 board, 51.437 board, human services department or social services department places a person in a congregate care facility that is located in another county, the placing county remains responsible for determining and reviewing the client's MA eligibility. A congregate care facility is a:

1. Child care institution.
2. Group home.
3. Foster home.
4. Nursing home.
5. Adult Family Homes (AFH).
6. Community Based Residential Facility (CBRF).
7. Any other like facility.

The placing county may request the assistance of the receiving county in completing applications for clients who are not MA certified and reviews for MA recipients. The receiving county must then forward the information to the placing county. The placing county remains responsible for determining the client's eligibility. If the placing county requests assistance from the receiving county, the placing county must provide the other agency with:

1. The client's name, age, and SSN.
2. The date of placement.
3. The client's current MA status.
4. The name and address of the congregate care facility in which the person has been placed.
5. The name of the county and agency making the placement.

When there is a dispute about responsibility, the social or human services department of the receiving county may initiate referral to the Department of Health and Family Services (DHFS Area Administration) office for resolution. Pending a decision, the county where the person is physically present must process the application, any changes, and reviews.

2.1.3.2.2 Applications Outside Wisconsin

Generally, an application should not be taken for a resident of Wisconsin when an individual is outside of Wisconsin. An exception is when a Wisconsin resident becomes ill or injured outside of the state or is taken out of the state for medical treatment. In this case, the application may be taken, using Wisconsin's application forms (2.1.4.5.1), by the public welfare agency in the other state. The Wisconsin ESA determines eligibility when the forms are returned.

2.1.3.5 Signing the Application

The client must sign the application form with his/her regular signature or with a mark except when:

1. A guardian signs for him/her. When an application is submitted with a signature of someone claiming to be the client's guardian, obtain a copy of the document that designates the signer of the application as the guardian. From the documents provided, ensure that the individual claiming to be the client's guardian can file an application on his/her behalf (2.1.3.5.2). File the copy of the document in the case record.

2. An authorized representative signs for the client (2.1.3.5.1).

3. Someone acting responsibly for the client signs the form on behalf of the client, if the client is incompetent or incapacitated.

Example: Carl is in a coma in the hospital. Sherry, a nurse that works at the hospital, can apply for MA on Carl's behalf.

4. A superintendent of a state mental health institute or center for the developmentally disabled signs on behalf of a patient.

5. A Warden signs the application for a client that is an inmate of a state correctional institution that is out for more than 24 hours (3.1.9.1).

6. The director of a county social or human services department delegates, in writing (retain a copy of this written authorization), to the superintendent of the county psychiatric institution the authority to sign and witness an application for residents of the institution.

   The social or human services director may end the delegation when there's reason to believe that the delegated authority is not being carried out properly.

7. The client's durable power of attorney (§ 243.07, Wis. Stats.) signs the application. A durable power of attorney is a person to whom the client has given power of attorney authority and agrees that the authority will continue even if the client later becomes disabled or otherwise incapacitated.

   When a submitted application is signed by someone claiming to be the client's durable power of attorney:

   a. Obtain a copy of the document the client used to designate the signer of the application as the durable power of attorney.

b. Review the document for a reference that indicates the power of attorney authority continues notwithstanding any subsequent disability or incapacity of the client.

Do not consider the application properly signed unless both of these conditions are met. File a copy of the document in the case record.

2.1.3.5.1 Authorized Representative

The client may authorize someone to represent him/her (IMM, Ch. I, Part A, 18.3.0).

If the client wishes to authorize someone to represent him/her when applying by mail, instruct him/her to complete the authorized representative section of the application form.

If the client needs to appoint an authorized representative when applying by telephone or in person, instruct the client to complete the Medicaid Authorization of Representative form (HCF 10126).

An authorized representative is responsible for submitting the signed application (completed insofar as able) and any required documents.

When appointing an authorized representative, someone other than the authorized representative must witness the client's signature. If the client signs with a mark, two witness signatures are required.

2.1.3.5.2 Guardian or Conservator

Your agency's social services department determines the need for a guardian or conservator (IMM, Ch. I, Part A, 19.0.0). Determine the guardian type specified by the court.

Only the person designated as the guardian of the estate (IMM, Ch. I, Part A, 19.2.0), guardian of the person and the estate, or guardian in general may sign the application. You may not require a conservator (IMM, Ch. I, Part A, 19.4.0) or guardian of the person (IMM, Ch. I, Part A, 19.1.0) to sign the application.

2.1.3.5.3 Witnessing the Signature

For mail and telephone applications, as well as reviews, the application form does not require an agency staff person to witness the signature. It does not affect the State of Wisconsin's ability to prosecute for fraud nor does it prevent the MA program from recovering benefits provided incorrectly due to a client's misstatement or omission of fact.

Two witnesses are required when the application is signed with a mark.

2.1.5.3.4 Spousal Impoverishment Cases

All spousal impoverishment MA applications and reviews require the signatures of **both** the institutionalized person and the community spouse, or of another authorized person (IMM, Ch. I, Part A, 18.0.0).

If the institutionalized person 's signature is missing, deny the application.

If the community spouse's signature is missing, test the institutionalized person's eligibility as if s/he were unmarried **unless** one or more of the following conditions exists:

1. The institutionalized person assigns to the state all rights to support from the community spouse.

2. The institutionalized person is not able to make an assignment of support from the community spouse because the institutionalized person is physically or mentally impaired, **and**

   The ESA has the right to bring a support proceeding against the community spouse without an assignment.

3. The denial of eligibility will be an undue hardship for the institutionalized person (5.10.4.4).

If one or more of the above conditions exists, test the institutionalized person's eligibility using spousal impoverishment policies.

When policy requires a witness to the institutionalized person's signature (IMM, Ch. I, Part A, 18.1.0 and IMM, Ch. I, Part B, 8.0.0), the community spouse's signature must also be witnessed.

This page last updated in Release Number : 05-01
Release Date: 01/11/05
Effective Date: 01/11/05

2.1.4 Application Processing

County/Tribal Social/Human Service agencies determine eligibility for all MA subprograms except:

1. Katie Beckett persons. (process by DHFS)
2. After care persons. (processed by Child Welfare agency)
3. Subsidized adoption persons (processed by Child Welfare agency)
4. SSI recipients (processed by SSA and DHFS)

Make a decision on the client’s MA eligibility as promptly as possible. Do not delay making a decision on one program because eligibility has not been determined for another program of assistance.

1. Process on the Same Application

   With the exceptions of the "Process Separately" subsection below, process everyone living in the same household on the same application.

   Unless you have verified the relationship, assume that a male who is living in the home but not married to the mother of the minor applicant is not the minor's father. If the relationship isn't verified, answer all the questions in the handbook about him as if he isn't part of the assistance group.

2. Process Separately

   Process the following person's in separate cases.

a. Institutionalized person (5.8.4) But when both members of a married couple are applying for community waivers (5.9), put them on the same application.

b. Minor ward of unrelated legal guardians. This is because the unrelated guardian:

   - Is not financially responsible for the minor, and

   - Cannot become eligible along with the minor on this application.

     If the legal guardian is related as an NLRR (3.5.3) follow the instructions in the paragraph "Mixed Family & NLRR Child".

     All guardians , unrelated and related, must sign the application (IMM I-A-18.0.0) .

3. Minors or 18 year olds who are living in licensed foster or group homes, or in licensed child care institutions. These cases are not processed in CARES. Process these cases manually on a separate application.

4. Minor parents (and their children) when all of the following conditions are true:

   a. The minor parent (3.5.1.15) has a child(ren) who is living in the household.

   b. The other parent of the minor parent's child(ren) is not living in the home; and,

c. The minor parent has been married.

5. Minor parent (and their child(ren) in common and the non-marital parent of the child(ren) in common where all of the following conditions are true:

a. The minor parent has a child(ren) who is living in the household;

b. The other parent of the minor parent's child(ren) is also living in the household; and

c. The minor parent and the other parent of the child in common are not married to each other.

2.1.4.1 Filing Date

The filing date is the day you receive page one of the CAF or an application with the client’s name, address and signature on it.

When an application is received by mail or fax, date-stamp or write the date that you received the valid application form.

2.1.4.2 Reopening a Case

2.1.4.2.1 Termination

If less than a calendar month has passed since a client’s eligibility has been terminated and the client is not open for any other program, the client can provide the necessary information to reopen his/her MA without filing a new application and re-sign the original application or page one of the CAF.

If more than a calendar month has passed since a client’s eligibility was terminated and the client is not open for any other program, the client must file a new application to reopen his/her MA.

2.1.4.2.2 Denial

If less than 30 days has passed since the client’s eligibility was denied, allow the client to re-sign the application or page one of the CAF.

If more than 30 days has passed since a client’s eligibility was denied and the client is not open for any other program, the client must file a new application to reopen his/her MA.

If the client is open for any other program of assistance, do not require him/her to re-sign his/her application or sign a new application.

2.1.4.3 Changes

Consider changes that occur between the filing date and CARES confirmation date in the application decision. Include changes which affect both eligibility and initial benefits, but do not hold or alter initial benefits after the CARES confirmation date.

For changes that occur after the processing date, follow the adequate and timely notice requirements (IMM, Ch. II, Part G).

2.1.4.4 Processing Timeframe

Process the application as soon as possible within 30 calendar days from the filing date and approve and/or deny (2.1.5.2, 2.1.5.3, 2.1.5.4) each subprogram of MA.

Extend the 30-day processing time up to an additional 10 days, if you are waiting for the client to provide additional information. CARES will issue a pending notice indicating the reason for the delay. To send a manual Negative Notice (HCF 16001) complete the following steps explaining:

1. The reason for the delay. Use Item 8 in the Negative Notice to explain the reason for the delay.

2. The information that must be provided to complete the application.

3. The date by which this information must be provided. Give the client at least 10 days to provide the requested information.

You may deny the application for failure to provide information if:

1. Information requested was a mandatory verification item (1.2), **and**

2. The client had the power to produce the verification within the period, but failed to do so, **and**

3. The client failed to provide the information within ten days and the 10th day was the last day of the 30-day processing period or after.

Example 1: A signed page one of the CAF is received on March 15, 2002. The first day of the 30-day period is March 16, 2002. The end of the 30-day period would be April 14, 2002. Since April 14, 2002 is a Sunday, extend the last day of the processing timeframe to the next business day. This last day would be April 15, 2002.

If the agency fails to take action (positive or negative) during the 30-day processing period, and the client is subsequently found eligible, restore any lost benefits using the original application date.

Example 2: A signed page one of the CAF is received on May 15th. The first day of the 30-day period is May 16th. The end of the 30-day period would be June 14th. The application is approved on June 20th, and the client is determined eligible. Certify MA for the client beginning May 1st.

2.1.4.5 Mail-In Processing

If an application is faxed into the ESA, the original application form is **not** required for processing. Do not deny MA because the original application form was not received.

Any items that are left blank should be assumed to be ‘No’ or $0.00 answers, unless there is a reason to deem the answer or lack of an answer as questionable (1.2.).

If a worker identifies a need for additional information (i.e., self-employment income and expense details), that is not detailed on the application form, contact the client by telephone or mail to obtain self-declared information. Document any additional self-declared information that a client provides through a telephone or mail contact in case comments.

If mandatory verification is missing or an item is deemed questionable, send a written list (EEVC) of what needs to be provided and the due date for the information to be received. Allow the client until the end of the 30th processing day or 10 days from the request, whichever is later, to provide the requested information. If the information is not provided, deny eligibility for MA for failure to verify mandatory or questionable information or failure to provide/clarify necessary information.

2.1.4.5.1 Application Forms

Use the following two application forms to determine a client’s eligibility for MA only:

1. Information and Application for Wisconsin Medicaid for the Elderly, Blind, and Disabled. (HCF 10101).

   Use this form when the client is elderly, blind, or disabled and wishes to apply for MA only.

2. Information and Application for Wisconsin Family Medicaid/BadgerCare (HCF 10100).

Use this application form when the client wishes to apply for a subprogram of Family MA only.

If a client fills out any other application form than (HCF 10101) or (HCF 10100) and the application includes a request for another program of assistance, do one of the following:

1. Process the application as a mail-in application for MA and schedule an interactive interview to complete the rest of the application.

2. Have the client sign the Voluntarily Declining Aid form (DWSW 2233) for the other program of assistance and process the application form as a mail-in application.

If the client indicates on (HCF 10100) that a member of the family is blind or disabled, process the application and request any additional information from the client needed to determine EBD MA eligibility.

2.1.4.6 Phone-In Processing

Complete client registration during the initial contact with the client. Mail the client page one of the CAF as well as the following items the same day the telephone application or review request is made:

1. Applying for Medicaid Fact Sheet (http://www.dhfs.state.wi.us/medicaid/index.htm).

2. Medicaid Eligibility and Benefits brochure (PCH 10025).

3. Brochures and fact sheets specific to the client's circumstances (http://www.dhfs.state.wi.us/medicaid/ index.htm).

The filing date is set when page one of the CAF is received at the ESA with the client's name, address, and signature. Do not complete the telephone interactive interview until this form has been returned.

Schedule a time (within regular agency hours) that is convenient for the client for the telephone application. Inform the client that s/he needs to be available without interruptions for a specified time period to complete the application. The telephone interview can be scheduled before or after the filing date has been established.

Ensure that the client has had a reasonable opportunity to connect with you for the telephone interview before considering him/her a "no show."

If at any time during the interview, the client wishes to apply for any other program, complete the MA application interview, determine MA eligibility, and schedule a face-to-face interview for the client at his/her earliest convenience.

Print out the Combined Application Form (CAF) from CARES and send it to the client. The client must initial and sign the CARES CAF on the signature page, and return it to the ESA. The client has until the end of the 30th day from the filing date or 10 days from the date the form is sent to him/her, whichever is later, to return the CARES CAF with any corrections indicated. If the form is not returned within this timeframe, deny the application for failure to sign the application form by overriding CARES eligibility with an 045 code on AGOE.

When the signed and completed application form is received timely, determine if the client made any changes to the information. If so, enter these changes into CARES. Determine eligibility and confirm the results using CARES. CARES will generate the appropriate approval or denial notice of decision.

If the signed and completed CARES CAF is returned after eligibility has been denied, treat the application as a new mail-in application. Contact the client for current information.

Example: A CARES CAF is sent to Mary on May 15th. Mary is expected to return it by May 30th. She does not return the CARES CAF signed by May 30th. Deny Mary's MA eligibility and allow the appropriate notices to be sent out.

Mary sends in the signed CARES CAF on July 7th. Treat this as a new application, and use the date that it is received by the agency as the filing date.

2.1.4.7 Minors Living Independently

Process the application of a minor living independently the same way as you would process an application for an adult (IMM I, A, 12.0.0).

This page last updated in Release Number : 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

2.1.5 Decision on Application

Make an eligibility decision for each completed application filed in your agency.

Once the client has completed the application process, complete the following using CARES and the appropriate policy documents:

1. Determine each person's eligibility.

2. Document case actions and circumstances in CARES case comments.

3. Notify the client on a CARES notice of decision or a manual positive or negative notice regarding his/her eligibility.

If a Supplemental Security Income (SSI) applicant/recipient or authorized representative submits an application at both the SSA and ESA, provide a notice of decision for each ESA application.

2.1.5.1 Withdrawal

A signed application form is an application for assistance. Applications are recorded as applications and must be formally disposed (IMM, Ch. I, Part A, 28.0.0). Withdrawing an application ends the application process already begun. Withdrawal does not negate the fact that the application was filed.

Only the applicant can decide to voluntarily withdraw an application. Some examples of when this might occur include:

1. Relatives are voluntarily willing to support.

2. The applicant does not wish to comply with one or more requirements.

3. The applicant knows s/he is not eligible.

Have the client complete a Voluntarily Declining Aid form (DWSW 2233) . Withdraw the case in CARES. This establishes an official date of application for determining any potential divestment of assets.

2.1.5.2 Approval

When you determine a group is eligible:

1. Approve the application for those MA subprograms in which the eligibility requirements have been met, or process a (HCF 10110, formerly DES 3070) when an eligibility decision is made manually.

2. Notify the client on a CARES-generated Notice of Decision or Positive Notice (HCF 16015) of the benefits for each program approved.

3. File in the case record a copy of all forms completed and sent that are not in the CARES history file.

2.1.5.2.1 Women, Infants, and Children (WIC) Referral

Whenever you approve MA to a group including a woman who is pregnant or recently gave birth or a child under five years old:

1. Refer the group to your local Special Supplemental Food Program for Pregnant Women, Infants, and Children (WIC) Program.

   CARES-generated notices will provide such a referral notice automatically.

   When you provide a manual positive notice to the MA group, include the following statement:

   "If someone in your household is pregnant, breastfeeding, has recently given birth or is under age five, you should be aware that for these persons a Special Supplemental Food Program for Pregnant Women, Infants, and Children (WIC) exists in your area. If you are interested, please call (insert your local WIC project's name here) at (insert your local WIC project's phone number here).

2. Provide the group with the WIC program pamphlet.

   Obtain copies of the pamphlet from your local program office of the Department of Health and Family Services, Division of Public Health.

2.1.5.3 Denial

An ineligible person may be eligible if s/he applies for MA on his/her own behalf on a separate application. Therefore, it is important to remember that a finding of "not eligible" in some instances may only mean "not eligible" as part of this application.

When you determine a group is ineligible:

1. Deny the application for those subprograms for which eligibility requirements have not been met.

2. Deny the application when the client does not provide information necessary for a determination.

3. Notify the client on a CARES Notice of Decision or Negative Notice (HCF 16001), of each program for which s/he is not eligible.

4. File, in the case record, the information on which the denial is based and a copy of the notice sent if not in CARES.

2.1.5.4 Approval and Denial

Send the applicant a CARES Notice of Decision or both a Positive (HCF 16015) and a Negative (HCF 16001) Notice when any of the following occurs:

1. The client is found eligible for a program and ineligible for another.

2. The client is found eligible for a program and is discontinued from another.

3. The application is approved, but a person in the group is denied.

4. Any other approval and denial combination.

This page last updated in Release Number : 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

2.1.6 Publications

For clients that are determined MA eligible, send out program information to the client that was not supplied at the initial filing of the application. This information could include such things as:

1. A fact sheet for the program for which they are eligible (http://www.dhfs.state.wi.us/medicaid/index.htm).

2. A Change Report (HCF 10137).

3. The Eligibility and Benefits brochure (PHC 10025).

2.1.6.1 Eligibility and Benefits

Provide each client the Eligibility and Benefits brochure (PHC 10025). Answer any questions s/he may have about the pamphlet's information.

2.1.6.2 Change Report

Provide each client with a Change Report (HCF 10137) when s/he applies and at any time s/he reports a change. It is not mandatory that the (HCF 10137) be used in reporting changes.

2.1.6.3 HealthCheck for Children

HealthCheck for Children is a program administered by the Department of Health and Family Service (DHFS), Division of Health Care Financing (DHCF) and provides early screening, diagnosis, and treatment of health problems for children receiving MA. Provide the HealthCheck brochure (PHC 1007) to families with children that are found eligible for MA.

This page last updated in Release Number : 03-01
Release Date: 01/01/03
Effective Date: 01/01/03

2.2 ELIGIBILITY AND REVIEWS

2.2.1 BEGIN DATES

Certify a person for MA with a begin date of the first day of the month in which s/he met all eligibility conditions.

Example 1: A client reduces countable assets so they no longer exceed the asset limit. MA begins on the first of the month in which her assets met the asset requirement.

Below are the exceptions to the first of the month policy. When all eligibility requirements are met, MA will not begin on a date earlier than:

1. **Community Waivers** - The program start date provided by the care manager.

2. **Deductible** - The date the deductible was met.

3. **EBD** – The disability onset date.

4. **Family Care MA and Family Care non-MA**- The Family Care enrollment date.

5. **Inmates** - The date the client is no longer an inmate of a public institution.

6. **Institutionalized** - His/her entry into the nursing home or hospital.

7. **Newborn** - The date the child was born.

8. **Person Adds** - The date the person moved into the household.

9. **Pregnant Woman** - The first of the month in which the pregnancy began. (5.2.6.1)

10. **QMB** - The first of the month following the eligibility determination (5.14.9.1).

11. **Recent Moves** - The date the client moved to Wisconsin.

    Exception: The begin date for an SSI recipient who moves to Wisconsin is the 1st of the month of the move.

Example 2: SSI recipient Mr. Nebble moves to Wisconsin from Vermont in April, 1999. He becomes eligible 04-01-99 in Wisconsin.

12. **SeniorCare** – The first of the month following the month in which all eligibility requirements have been met (5.16.5).

13. **Wisconsin Well Woman Medicaid** - Certify the client for 12 months beginning with and including the certification month. Backdate to whichever is more recent:

    a. Up to three months prior to the filing date.
    b. To the first day of the month in which the date of the diagnosis occurs.
    c. January 1, 2002.

2.2.1.1 Backdates

If certifying for retroactive MA, do not go back further than the first of the month, three months prior to the application month. Certify the person for any backdate month in which s/he would have been eligible had s/he applied in that month.

A backdate request can be made at any time, except in the case where backdating the client's eligibility results in a deductible for the backdated period.

If a client has incurred a bill from a MA certified provider during a backdate period, instruct the client to contact the provider to inform them to bill MA. The client may be eligible to receive a refund of a portion of the amount billed from the provider.

Example: Al applied for MA on April 6th, and was found eligible for CARES category MS. At the time of application, Al did not request a backdate. Al finds out in September that he had bills in February. Al can ask to have his eligibility backdated through February. Al meets all non-financial and financial eligibility criteria in the months of February and March. His worker certifies him for MS for both months. If Al had excess income for either February or March, he could not receive backdated coverage for February or March, because a six-month deductible period could not be established.

2.2.1.1.1 Assets

A person's asset eligibility in a backdate month is determined by whether or not s/he had excess assets on the last day of the month. If s/he had excess assets on the last day of the month, s/he is ineligible for the entire month. If s/he was asset eligible on the last day of the month, s/he is eligible for the whole month.

2.2.1.1.2 BadgerCare

There is no backdating for BadgerCare.

2.2.1.1.3 Family Planning Waiver (FPW)

There is no backdating for Family Planning Waiver (5.15.3).

2.2.1.1.4 QMB

Backdating for QMB only occurs for select circumstances. (5.14.09).

2.2.1.1.5 SeniorCare

There is no backdating for SeniorCare (5.16.5.2).

2.2.1.1.6 Pregnant Women

Backdate a pregnant woman to whichever is more recent:

1. The first of the month in which the pregnancy began.

2. The first of the month, three months prior to the month of application. If a woman was pregnant before the date of her application, backdate her MA, even though she is not pregnant on the date of application. Do not, however, give her an extension. Before backdating her MA, verify that she has met all the eligibility requirements during the retroactive period.

2.2.1.1.7 Backdating Wisconsin Well Woman MA (WWWMA) clients for Wisconsin Well Woman Program (WWWP)

When certifying a woman for WWWMA through WWWP (with the DPH 4818) manually certify any woman who has met the eligibility requirements for 12 months with one of the following start dates:

1. The day following the diagnosis date (rather than the first of the month in which the diagnosis occurred), or

2. Up to 3 months prior to the filing date, if the diagnosis date is older than three months in the past.

   If the woman will turn 65 within the projected 12 month certification period, certify her though the end of the month in which she reaches 65 years of age.

2.2.1.1.8 Backdating Wisconsin Well Woman MA (WWWMA) clients enrolled in Family Planning Waiver (FPW) in CARES.

When certifying a woman for WWWMA through FPW, manually certify any woman who has met the eligibility requirements for 12 months with one of the following starts dates.

1. The day following the diagnosis date (rather than the first of the month in which the diagnosis occurred), or
2. Up to 3 months prior to the WWWMA filing date, if the diagnosis date is older than three months in the past.

2.2.2 REVIEW DATES

A review is the process during which you reexamine all eligibility factors subject to change and decide if eligibility continues. The group's continued eligibility depends on its timely completion of a review. Each review results in a determination to continue or discontinue assistance. Provide a positive or negative notice before the end of the current eligibility period once you have completed the review.

2.2.2.1 Not Time Limited Cases

The first required eligibility review for all MA cases that are not time limited is 12 months from the certification month.

2.2.2.2 Time Limited cases

Time limited cases are pregnant women, continuously eligible newborns, deductibles and extensions.

2.2.2.2.1 Newborns

Schedule the review date for 12 months from the date of birth.

2.2.2.2.2 Pregnant Women

Schedule the review date within two months of the pregnancy's end.

2.2.2.2.3 Deductible

Do not schedule a review for a case that did not meet its deductible unless someone in the case was open for MA, or is open for another program. For cases that did meet the deductible, schedule the review date for six months from the start of the deductible period.

2.2.2.2.4 Elderly, Blind, Disabled (EBD)

Review Elderly, Blind, Disabled (EBD) cases within 12 months from the eligibility date, unless an earlier disability review is indicated.

2.2.2.2.5 Agency Option

The agency may review any case at any other time when the agency can justify the need.

2.2.2.2.6 AFDC MA Extensions

Set the review date for 12 months from the certification month. The following are AFDC MA 12-month extensions (5.6.3):

1. $30 and 1/3.
2. $30 disregard ended.
3. Increased hours of employment.
4. Increased earnings.
5. Increased earnings along with other income (changed or unchanged).

See 5.6.6 for instructions for determining whether a child support extension should last for 4 or 12 months.

This page last updated in Release Number: 03-01
Release Date: 01-01-03
Effective Date:01-01-03

2.2.3 CHOICE OF REVIEW

The client has the choice of the following methods for any MA only review:

1. Face-to-Face Interview.
2. Mail-In.
3. Telephone Interview.

A face-to-face review is not required for any type of MA.

This page last updated in Release Number : 03-01
Release Date : 01-01-03
Effective Date :01-01-03

2.2.4 REVIEW OF PROCESSING

CARES sends a notice of review the first Friday of the month before the review month. Do not schedule the review until the month that the review is due. For example, if CARES sends out the review letter on July 7th for a review due in August, do not schedule the review until August.

Do not require someone to witness the signature of an authorized representative when the person signing the review is the same person who signed the most recent application or review.

2.2.4.1 Grace Month

A “grace month” is a one-month extension beyond the review month of MA eligibility when a client is late in completing his/her review or has missed his/her review. The grace month can be viewed on MMIS screen RE. CARES will continue to show the actual review date for these assistance groups (AGs), but will not close the AG until the end of the grace month.

All AGs of MA will receive the grace month, including Medicare Beneficiaries, except for:

1. Those AGs that are receiving time-limited MA (2.2.2.2)
   and
2. Women that are in the FPW extension phase (5.15.9).

This page last updated in Release Number: 03-01
Release Date: 01-01-03
Effective Date:01-01-03

3 NONFINANCIAL REQUIREMENTS

GENERAL NONFINANCIAL

3.1 RESIDENCE

3.1.1 ELIGIBILITY

A person must be a Wisconsin resident to be eligible for MA. S/he must:

1. Be physically present in Wisconsin. There is no required length of time the person has to have been physically present.

2. Express intent to reside here (3.1.2).

Example: This is George's first day in Wisconsin. He states that he intends to reside in Wisconsin. For MA purposes, George is a Wisconsin resident.

3.1.1.1 Migrant Farm Worker

A migrant who meets the following conditions is a Wisconsin resident:

1. His/her primary employment in Wisconsin is in the agricultural field or cannery work,

2. S/he is authorized to work in the US,

3. S/he is not related (immediate family) by blood or marriage to the employer (as distinguished from a "crewleader"), and

4. S/he routinely leaves an established place of residence to travel to another locality to accept seasonal or temporary employment.

This page last updated in Release Number : 01-05
Release Date: 10/01/01
Effective Date: 10/01/01

3.1.2 INTENT

Intent applies to any adult age 18 or older who is capable of indicating intent. An adult is incapable of indicating intent when:

1. His/her I.Q. is 49 or less or s/he has a mental age of 7 or less, based on tests acceptable to Wisconsin's Department of Health and Family Services (DHFS); or

2. S/he is judged legally incompetent by a court of record; or

3. Medical documentation obtained from a physician, psychologist, or other person licensed by Wisconsin in the field of developmental disability supports a finding that s/he is incapable of indicating intent.

This page last updated in Release Number: 01-05
Release Date : 10/01/01
Effective Date : 10/01/01

3.1.3 DETERMINING RESIDENCE

3.1.3.1 Under Age 21

Not in institution

A person under age 21 and not residing in an institution is a Wisconsin resident if s/he is:

1. Living here more than temporarily.

2. Living here temporarily, not receiving MA from another state, and is a migrant farm worker or living with a family member who is a migrant farm worker.

3. Living in another state when Wisconsin or one of its county agencies has legal custody of him/her.

4. Living here and is an EBD MA case (the person's eligibility is based on blindness or disability.)

In an institution

The residence of an institutionalized person under age 21 when his/her parents or legal guardian lives outside of Wisconsin is the state in which the parent or legal guardian states the institutionalized person is present, and intends to stay.

If the parents have abandoned him/her and no legal guardian has been appointed, his/her residence is the state in which the institution is, if the person making the MA application lives in that same state.

If s/he is married, his/her residence is the institution's state.

3.1.3.2 Age 21 and Over

In an institution

The residence of an institutionalized person aged 21 or over is the state in which s/he is residing with the intent to remain.

If s/he is incapable of indicating intent, his/her residence is determined in the same way as the residence of an institutionalized person under age 21.

This page last updated in Release Number: 01-05
Release Date: 10/01/01
Effective Date: 10/01/01

3.1.4 SPECIAL SITUATIONS

3.1.4.1 SSP Payment

The State Supplementary Payment (SSP) is the portion of an SSI payment paid by a state, not by the federal government. An SSP recipient's residence is the state making the SSP payment.

3.1.4.2 IV-E Children

Federal financial participation is available under Title IV-E of the Social Security Act to pay for all or part of a person's foster care or subsidized adoption. IV-E eligible children are categorically eligible in the state where they reside. This policy applies only to children who are placed in not-for-profit facilities and it applies only to MA coverage. It does not affect any maintenance payments for substitute care.

3.1.4.3 Homeless Persons

A homeless person living in Wisconsin meets the requirement of being physically present in Wisconsin. The agency must, by using its own address or some other fixed address, make MA cards available to eligible applicants who have no fixed dwelling place or mailing address.

3.1.4.4 Non IV-E Foster Children

Wisconsin certifies non IV-E foster children living in another state when Wisconsin or one of its county/tribal agencies has legal custody of the child.

Non IV-E foster children are automatically eligible if they are recieving a Non IV-E payment from a Wisconsin foster care agency. These cases are certified manually outside of CARES.

This page last updated in Release Number : 05-01
Release Date : 01/11/05
Effective Date : 01/01/05

3.1.5 ABSENCE

Once established, Wisconsin residence is retained until abandoned. Being out-of-state, in and of itself, is not abandoning residence. Residence is not abandoned when an MA group or group member is temporarily out-of-state.

3.1.5.1 Temporary Absence

Temporary absence ends when another state determines the person is a resident there for MA purposes.

This page last updated in Release Number : 00-01
Release Date: 01/01/00
Effective Date: 01/01/00

3.1.6 EFFECTIVE DATE OF MA FOR SSI RECIPIENTS

SSI recipients who move to Wisconsin become eligible for MA in Wisconsin on the 1st of the month of the move.

Example: SSI recipient Mr. Nebble moves to Wisconsin from Vermont in April, 1999. He becomes eligible 04-01-99 in Wisconsin..

This page last updated in Release Number: 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

3.1.7 Wisconsin Veteran's Home

Waupaca County receives and processes all MA applications and reviews for residents of the Wisconsin Veterans Home at King, regardless of the county of residence (IMM I, A 4.3.0).

This page last updated in Release Number: 00-01
Release Date: 01/01/00
Effective Date: 01/01/00

3.1.8 INTERSTATE pLACEMENTS

An interstate placement occurs when a state or state contracted agency arranges for an individual to be admitted to an institution in another state.

"Arranges for" means any action by a state or state-contracted agency beyond providing information to the person or the person's family (or both). Do not consider the following to indicate interstate placement:

1. Giving information to individuals about another state's MA program.

2. Giving information to persons about the availability of health care services and facilities in another state.

3. Helping a person locate an institution in another state when that person is capable of indicating intent and independently decides to move.

When a state or state-contracted agency makes the placement, the state making the placement is the person's MA residence. The person's intent makes no difference. If Wisconsin places a person into an institution in Minnesota, Wisconsin remains the state of residence for MA even if the **person expresses an intent to reside in Minnesota.**

If Minnesota places a person in Wisconsin, Minnesota is the MA residence despite an indicated intent by the person to make his/her home in Wisconsin.

Follow this rule even when placement is made by a state because that state lacks a sufficient number of appropriate facilities to provide services to its residents.

Use the general rule of residency when a competent person leaves an institution in which s/he was placed by another state. But if the person is not able to indicate intent, MA residence continues to be that of the state that made the placement.

3.1.8.1 Reciprocal Agreement

Wisconsin has a reciprocal agreement with some other states (see the list below) that persons who are in out-of-state institutions, but were not placed there as a result of an interstate placement, are the residents of the state where the institution is. For example, a person institutionalized in Wisconsin who would otherwise be considered a resident of Minnesota is a Wisconsin resident for MA purposes.

These are the states with whom we have this agreement:

Alabama	Kentucky	Pennsylvania
Arkansas	Maryland	S. Carolina
California	Minnesota	S. Dakota
Florida	Mississippi	Texas
Georgia	New Mexico	Virginia
Idaho	N. Dakota	W. Virginia
Kansas	Ohio	

3.1.8.2 Disputes

The state in which the person is physically present is the MA residence when two or more states disagree about the person's residence.

If you determine that a state other than Wisconsin is the person's legal residence, contact the other state about providing MA coverage.

This page last updated in Release Number : 02-03
Release Date : 07/01/02
Effective Date : 07/01/02

3.1.9 INMATES

Do not count inmates of public institutions (1.1.2, #4) as members of the household. An inmate of a public institution is a person who is a prisoner in a jail, prison, or other correctional facility, and who does not reside outside of the institution for more than 24 hours at any one time.

If an inmate of a public institution is admitted, as an inpatient, to a medical institution for 24 hours or more, and is otherwise eligible, manually certify him/her for MA from the admission date through the discharge date.

“Public institution” means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. The term “public institution” does not include a medical institution (5.8.1), a publicly operated community residence that serves no more than 16 residents, or a child care institution in which foster care maintenance payments are made under title IV-E.

Note: The following are not publicly operated community residences, even though they may accommodate 16 or fewer residents:

1. Residential facilities located on the grounds of, or immediately adjacent to, any large institution or multiple purpose complex, or

2. Correctional or holding facilities for individuals who are prisoners, have been arrested or detained pending disposition of charges, or are held under court order as material witnesses or juveniles.

Procedures for processing inmates of state facilities are covered in 3.1.9.1.

3.1.9.1 Inmates of State Correctional Institutions

Use the following process for inmates of state correctional institutions:

1. Department of Corrections (DOC) staff submits a paper application (HCF 10100 or HCF 10101). The mailing address for the inmate will be the DOC central office. Superintendents of state correctional facilities (Wardens) may sign the application for the inmate. Refer to 3.1.9.2 for the list of state correctional facilities at which the Warden may sign the application.

2. Process the inmate as a one-person household and code ANLA with a living arrangement of "01- Independent (Home/Apt/Trlr)"

3. If the inmate is between the ages of 19 and 64, and is not a pregnant woman, DOC will submit a Medicaid Disability Application (HCF 10112) along with the MA application (HCF 10100 or HCF 10101). Forward the disability application to the Disability Determination Bureau (DDB), even if there is no Confidential Information Release Authorization – Release to Disability Determination Bureau form (HCF 14014) signed by the inmate, and pend the MA application in CARES until a disability determination has been made. If the disability determination is not made within the 30-day processing period, send a manual notice to the designated DOC staff person that the MA eligibility determination has been delayed because additional information is needed.

   Note: In many cases a Confidential Information Release Authorization – Release to Disability Determination Bureau form (HCF 14014) will not be necessary for DDB to obtain medical information from DOC. If a release is necessary, DDB will obtain it from DOC.

4. If the client is eligible, close the case in CARES by changing the request on ACPA for MA to "N". Suppress CARES generated notices for MA and any program the client has not requested. Manually certify the inmate with the appropriate medical status code (see below), from the hospital admission date through the date of discharge. If the client has not yet been discharged, certify the client from the date of admission through the estimated discharge date. Send a manual positive notice to DOC indicating the dates of eligibility.

   Note: It is not necessary to provide a ten-day notice of termination for MA when the reason for termination is the return of the inmate to prison.

5. If the client is ineligible, confirm the denial on CARES, and allow CARES generated notices to be sent to the designated DOC staff person.

Category	Medical Status Codes
Minors Under 18	
Income Below AFDC-Related Categorically Needy Limit	38
Income Below AFDC-Related Medically Needy Limit	39
18-year-olds	
Income Below AFDC-Related Categorically Needy Limit	38
Pregnant Women	
Income Below AFDC-Medicaid Limit	31
Income Below AFDC-Related Categorically Needy Limit	38
Income Below AFDC-Related Medically Needy Limit	39
Income Below Healthy Start Categorically Needy Limit	PW
60-day Extension Period E3	E3
Income Below Healthy Start Medically Needy Limit	P1
60-day Extension Period	E4
Elderly	
Income and Assets Below SSI-Related Categorically Needy Limit	4
SSI-Related Medically Needy	5
Blind	
Income and Assets Below SSI-Related	14

Categorically Needy Limit	
SSI-Related Medically Needy	15
Disabled	
Income and Assets Below SSI-Related Categorically Needy Limit	22
SSI-Related Medically Needy	23
Undocumented Aliens	AE

3.1.9.2 State Correctional Institutions

Brown
Institutions Green Bay Correctional Institution
Sanger Powers Correctional Institution

Chippewa
Highview Correctional Institution
Stanley Correctional Institution

Columbia
Columbia Correctional Institution

Crawford
Prairie du Chien Correctional Facility (Division of Juvenile Corrections)

Dane
Oakhill Correctional Institution
Oregon Correctional Institution
Thompson Correctional Institution

Dodge
John Burke Correctional Center
Dodge Correctional Institution
Fox Lake Correctional Institution
Waupun Correctional Institution

Douglas
Gordon Correctional Center

Fond du Lac
McNaughton Correctional Center

Taycheedah Correctional Institution

Grant
Supermax Correctional Institution

Jackson
Black River Correctional Institution
Jackson Correctional Institution

Kenosha
Kenosha Correctional Center

Lincoln
Lincoln Hills School (Division of Juvenile Corrections)

Milwaukee
Marshall Sherrer Correctional Center
Milwaukee Secure Detention Facility
Milwaukee Women's Correctional Facility
Felmers O'Chaney Correctional Center

Racine
Robert Ellsworth Correctional Center
Racine Correctional Institution
Racine Youthful Offender Correctional Facility
Southern Oaks Girls School

St. Croix
St. Croix Correctional Center

Sauk
New Lisbon Correctional Center

Sawyer
Flambeau Correctional Center

Sheboygan
Kettle Moraine Correctional Institution

Waukesha
Ethan Allen School (Division of Juvenile Corrections)

Waushara
Redgranite Correctional Institution

Winnebago

Drug Abuse Correctional Center
Oshkosh Correctional Institution
Winnebago Correctional Center
Wisconsin Resource Center (Department of Health and Family Services)

This page last updated in Release Number : 02-03
Release Date : 07/01/02
Effective Date : 07/01/02

3.2 CITIZENS AND ALIENS

3.2.1 U.S. CITIZENS (citizenship)

All U.S. citizens are entitled to apply for Medicaid (MA) and, if they meet all of the eligibility requirements, to receive full MA benefits.

A U.S. citizen is anyone who:

1. Was born in the U.S. The U.S. includes Puerto Rico, Virgin Islands, Northern Mariana Islands, and Guam.
2. Was born to a U.S. citizen while s/he was abroad.
3. Is a naturalized U.S. citizen.
4. Is a child born outside the U.S. and has met all of the following criteria at any time after February 26, 2001:

   a. At least one parent of the child is a citizen of the U.S., whether by birth or naturalization.

   b. The child is under the age of 18.

   c. The child is residing in the U.S. in the legal and physical custody of the parent.

   Adopted children automatically become U.S. citizens if they meet the all of the above criteria and if they were:

   a. **Adopted under the age of 16**. If the child has been in the legal custody of and has resided with the adopting parent or parents for at least two years.

   b. **Adopted while under the age of 18**. If the child has been in the legal custody of and has resided with the adopting parent or parents for at least two years and is a sibling of another adopted child who is under 16.

c. **Orphans adopted while under the age of 16 and have had their adoption and immigration status approved by the INS (Form I-171, "Notice of Approval of Relative Immigrant Visa Petition").** These children need not have lived with the adoptive parents for two years.

d. **Orphans adopted under the age of 18, who have had their adoption and immigration status approved by the INS, and are siblings of another adopted child who is under the age of 16.** These children need not have lived with the adoptive parents for two years.

This page last updated in Release Number : 02-03
Release Date: 07/01/02
Effective Date: 07/01/02

3.2.2 ALIENS

Aliens are persons who reside in the U.S., but are not U.S. citizens. The following aliens are entitled to apply for MA and, if they meet all of the eligibility requirements, to receive full MA benefits.

1. A refugee admitted under Immigration & Nationality Act (INA) Section 207.

   A refugee is a person who flees his/her country due to persecution or a well-founded fear of persecution because of race, religion, nationality, political opinion, or membership in a social group.

   An alien admitted under this status may be eligible for MA even if his/her alien status later changes.

2. An asylee admitted under INA Section 208.

   Similar to a refugee, this is a person who seeks asylum and is already present in the U.S. when s/he requests permission to stay.

   An alien admitted under this status may be eligible for MA even if his/her alien status later changes.

3. An alien whose deportation is withheld under INA Section 243(h) and such status was granted prior to April 1, 1997, or an alien whose removal is withheld under INA Section 241(b)(3) on or after April 1, 1997.

   An alien admitted under this status may be eligible for MA even if his/her alien status later changes.

4. A Cuban/Haitian entrant.

   An alien admitted under this status may be eligible for MA even if his/her alien status later changes.

5. An American Indian born in Canada who is at least 50% American Indian by blood, or an American Indian born outside of the U.S. who is a member of a Federally recognized Indian tribe.

6. **Lawfully admitted for permanent residence under the INA.

7. **Paroled into the U.S. under INA Section 212(d)(5).

8. **Granted conditional entry under immigration law in effect before April 1, 1980 [INA Section 203(a)(7)].

9. **An alien who has been battered or subjected to extreme cruelty in the U.S. and meets certain other requirements.

10. **An alien whose child has been battered or subjected to extreme cruelty in the U.S. and meets certain other requirements.

11. **An alien child who resides with a parent who has been battered or subjected to extreme cruelty in the U.S. and meets certain other requirements.

   **If these aliens lawfully entered the U.S. on or after August 22, 1996, they must also be one of the following:

a. Is an alien lawfully residing in Wisconsin who is an honorably discharged veteran of the U.S. Armed Forces.

b. Is an alien lawfully residing in Wisconsin who is on active duty (other than active duty for training) in the U.S. Armed Forces.

c. Is an alien lawfully residing in Wisconsin who is the spouse, unmarried dependent child, or surviving spouse of a person described in "a" or "b".

d. Is an Amerasian.

e. Has resided in the U.S. for at least five years since his/her date of entry.

Alien status is an individual eligibility requirement. It does not affect the eligibility of the MA Group. The eligible citizen spouse or child of an ineligible alien may still be eligible even though the ineligible alien is not.

Verify alien status using the procedures in the IMM, Ch. 1, Part D, 4.0.0.

3.2.2.1 Public Charge

The receipt of MA or BadgerCare by the individual or by the children or spouse for whom the individual is legally responsible does not establish the person as a public charge.

3.2.2.2 INS Reporting

Do not refer an alien client to Immigration and Naturalization Service (INS). The one exception is you may refer the alien if you need information for administering the MA program. For example, if MA needs to determine client’s location for repayment or fraud prosecution, or to determine his/her alien status.

This page last updated in Release Number : 02-03
Release Date:07/01/02
Effective Date: 07/01/02

3.2.3 EMERGENCY SERVICES

An alien found ineligible under regular MA due to citizenship status can be eligible for emergency MA if they meet all other eligibility requirements. (Aliens are not required to have a SSN for emergency services.) If they would be eligible for any MA category including Healthy Start, they qualify. However, they are ineligible if the only category of MA they would be eligible for is BadgerCare.

An emergency means a medical condition that shows acute symptoms of sufficient severity (including severe pain) such that the lack of immediate MA could result in one or more of the following:

1. Serious jeopardy to the patient's health.
2. Serious impairment to bodily functions.
3. Serious dysfunction of a bodily organ or part.

The medical provider will submit a claim to EDS and EDS will determine if the situation was an emergency that is covered by MA.

If a non-qualifying alien provides you with a “Provider Certification of Emergency Form” at the time of application, determine his/her eligibility for emergency services. You do not have to determine if an emergency exists. Your responsibility is to see if the non-qualifying alien meets all other eligibility requirements and to certify if s/he is eligible.

Complete and return a HCF 10110 (Formerly DES 3070). The HCF 10110 may be returned by:

1. Mail: EDS
   P.O. Box 7636
   Madison, WI 53707

2. E-mail: eds_3070@dhfs.state.wi.us

3. Fax: (608) 221-8815

Use the AE medical status code. Emergency coverage lasts from the time of the first treatment for the emergency until the condition is no longer an emergency. The person will not receive a MA card because MA ends when the emergency ends.

EDS needs a beginning and end date to process eligibility. In setting the end date, use the last day of the emergency. If that is not known, use the last day of the month in which the emergency is expected to end.

3.2.3.1 MA Deductible

Aliens who apply for emergency services may become eligible by way of the MA deductible. If, on the date they apply, they are eligible in all respects except income, apply the same deductible policies (4.9.1) to them as to any other client.

3.2.3.2 Pregnancy

All labor and delivery services are emergency services and are covered under emergency MA for eligible non-qualifying aliens. An alien who gives birth and is eligible for emergency MA is eligible for a 60-day pregnancy extension. The extension covers emergency MA only. The emergency does not have to be related to the pregnancy.

A pregnant non-qualifying alien may apply for emergency services up to one calendar month before her due date. Certify an eligible pregnant non-qualifying alien from the date of application, if it is no more than one calendar month prior to her due date, through the end of the month in which the 60th day occurs following her due date. Adjust the certification period based on the actual pregnancy end date, once it is known.

Example 1: Sara is a pregnant non-qualifying alien applying for emergency services. Sara has two weeks until her due date, which is March 3rd. Certify Sara for emergency services from the date of application through

the end of May.

Example 2: Erica applied for emergency services because she was a pregnant non-qualifying alien on March 13th. Her expected due date is April 5th. Erica is certified for emergency services from March 13th through the end of June. Erica delivers her son on March 15th. Her certification period should be adjusted from March 13th through the end of May.

If a pregnant non-qualifying alien applies prior to the calendar month before her due date and she has not received a service, deny her emergency services eligibility because she has not received a service.

If a woman applies for emergency services after her pregnancy has ended, certify her from the pregnancy end date through the end of the month in which the 60th day occurs.

Example 3: Vienne miscarries on April 5th, which is more than one month from her due date of July 15th. Vienne applies on April 6th for emergency services. Certify Vienne for emergency services from April 5th through the end of June.

3.2.3.3 Alien Status Chart

CARES TCTZ Code	Alien Status	Arrived Before 08/22/96	Veteran*/ Amerasian Arrived before 8-22-96	Arrived on or after 8-22-96	Veteran*/ Amerasian Arrived on or after 8-22-96
01	Lawfully admitted for permanent residence	Eligible	Eligible	Ineligible for 5 years	Eligible
02	Permanent resident under color of law (PRUCOL)	Ineligible	Ineligible	Ineligible	Ineligible
03	Lawfully present under Section 203(a)(7)	Eligible	Eligible	Ineligible for 5 years	Eligible
04	Lawfully present under Section 207(c)	Eligible	Eligible	Eligible	Eligible
05	Lawfully present under Section 208	Eligible	Eligible	Eligible	Eligible
06	Lawfully present under Section 212(d)(5	Eligible	Eligible	Ineligible for 5 years	Eligible
07	IRCA (No longer valid)	N/A	N/A	N/A	N/A
08	Lawfully admitted - temporary	Ineligible	Ineligible	Ineligible	Ineligible

09	Undocumented Alien	Ineligible	Ineligible	Ineligible	Ineligible
10	Illegal Alien	Ineligible	Ineligible	Ineligible	Ineligible
11	Cuban/Haitian Entrant	Eligible	Eligible	Eligible	Eligible
12	Permanent Resident	Ineligible	Ineligible	Ineligible	Ineligible
13	Special agricultural worker under Section 210(A)	Ineligible	Ineligible	Ineligible	Ineligible
14	Additional special agricultural worker under Section 210(A)	Ineligible	Ineligible	Ineligible	Ineligible
15	Withheld deportation - Section 243(h)	Eligible	Eligible	Eligible	Eligible
16	Battered Alien	Eligible	Eligible	Ineligible for 5 years	Eligible
None	Foreign-born American Indian	Eligible	Eligible	Eligible	Eligible

*"Veteran" includes certain veterans and active duty servicemen and women, their spouses, dependent children, or certain surviving spouse.

This page last updated in Release Number : 02-04
Release Date: 10/01/02
Effective Date:10/01/02

3.3 MEDICAL SUPPORT LIABILITY

3.3.1 Assignment

Medical Support Liability (MSL) means all MA clients must sign over to the State of Wisconsin all of their rights to payments from:

1. Court ordered medical support, or
2. Other third party payors of their medical expenses.

This is an eligibility requirement.

The client complies with this requirement by signing the application form. The assignment of medical support includes all unpaid support and all ongoing support obligations for as long as MA is received.

The Economic Support Agency (ESA) must give a Notice of Assignment (DWSW-2477) to each client. If the client refuses to sign this form, the ESA must complete the lower portion of the form and file it in the case record. Do this no later than at the time of the interview. Give the client a copy of the notice. Do not delay processing a Medicaid application while waiting for the form to be signed. Do not penalize the client for not signing this form. File the original in the case record.

This page last updated in Release Number : 04-01
Release Date: 02/27/04
Effective Date: 02/27/04

3.3.2 Recovery of Birth Costs

Fathers who were not part of the final MA fiscal test group, which includes the mother and fetus, at the time of certification can be required to pay their children's birth costs. Inform pregnant MA applicants that the child's father could be held responsible for repayment of birth costs

This page last updated in Release Number : 04-01
Release Date: 02/27/04
Effective Date: 02/27/04

3.3.3 Referral to CSA

Refer anyone, including any child, for whom MA is requested or received to the county CSA as follows:

1. Pregnant woman. Advise all unmarried pregnant women that they are not required to cooperate with the CSA during the pregnancy and for two

months after the end of pregnancy.

2. Child receiving SSI, if the caretaker requests child support services for the child. Do not sanction this caretaker if s/he does not cooperate with the CSA.

3. Mother and father not married to one another and paternity has not been established by court action. This includes a non-marital parent even when:

a. A Statement of Paternity (IMM, Ch. I, Appendix 29g) has been completed,

b. Both parents are in the home.

4. One or both of the natural or adoptive parents is not living in the household. Do not refer to the CSA when the only reason a parent or stepparent is not in the home is because s/he is in the military.

5. Natural parents in the home, but:

a. Child was born prior to their marriage, and

b. Paternity not established by court action, or the birth not legitimized after their marriage.

CARES automatically sends a referral to the CSA when a case is confirmed. Fill out the absent parent screens completely and accurately so the CSA gets a good referral. Only complete the Referral to Child Support form (DES 3080) when CARES is not sending the referral. The CSA works with the mother to establish paternity for the child, if paternity has not been established, and obtains the medical support order.

This page last updated in Release Number : 04-01
Release Date: 02/27/04
Effective Date: 02/27/04

3.3.4 MSL Cooperation

Unless the person is exempt or there is good cause for refusing to cooperate, each client must, as a condition of eligibility, cooperate in:

1. Establishing the paternity of any child born out of wedlock for whom MA is requested or received, and

2. Obtaining medical support for the client and for any child for whom MA is requested or received.

Cooperation includes any relevant and necessary action to achieve the above.

As a part of cooperation, the client may be required to:

1. Provide verbal or written information known to, possessed by, or reasonably obtainable by the client.

2. Appear as a witness at judicial or other hearings or proceedings.

3. Provide information, or attest to the lack of information, under penalty of perjury.

4. Pay to the clerk of court or the CSA any court ordered medical support payments received directly from the absent parent after support has been assigned.

5. Attend office appointments as well as hearings and scheduled genetic tests.

3.3.4.1 Polygraph

Do not require participation in a polygraph examination.

A client may voluntarily participate in a polygraph examination. The results, however, may only be used to challenge or uphold other evidence. They may not be used as conclusive evidence against the client.

3.3.4.2 Failure to Cooperate

Sanction clients, applying for either Family MA or EBD MA, who refuse to cooperate, unless there is good cause (3.3.5). Do not sanction the following if s/he does not meet the MSL cooperation requirement:

1. Pregnant women.
2. Minors.
3. Dependent 18-year-olds (3.5.1.3).

The CSA determines if there is non-cooperation. The ESA determines if good cause exists. If there is a dispute, the CSA makes the final determination of cooperation. S/he remains ineligible until s/he cooperates, establishes good cause, or cooperation is no longer required. This applies also to persons in a MA extension (5.6.3).

Example: Mary, a disabled parent, is applying for MA for her and her son, Michael. She refuses to cooperate in obtaining medical support for Michael. Mary meets all other non-financial and financial criteria for Family MA and EBD MA.

Mary is not eligible for EBD MA or Family MA, because she will not cooperate in obtaining medical support for Michael. Even though Mary has not cooperated in obtaining medical support for Michael, he remains eligible for MA.

For a pregnant woman, failure to cooperate cannot be determined prior to the end of the month in which the 60th day after the termination of pregnancy occurs.

This page last updated in Release Number : 04-01
Release Date: 02/27/04
Effective Date: 02/27/04

3.3.5 Claiming Good Cause

Any parent or other caretaker relative who applies for or receives MA and who refuses to cooperate in establishing paternity and obtaining medical support may claim good cause. S/he must:

1. Specify the circumstance that is the basis for good cause, and
2. Corroborate the circumstance according to the evidence requirements in 3.3.5.5.

3.3.5.1 Notice

The ESA or Social Service agency must issue a Good Cause Notice (DES 2018) to all clients whenever a child is added to the MA card. The notice describes the right to refuse to cooperate for good cause in establishing paternity and securing medical support.

The ES worker and the client must sign and date the notice. File the original in the case record and give the client a copy. The CSA refers anyone who wants to claim good cause back to you.

3.3.5.2 Claim

Give a Good Cause Claim form (DWSW 2019) to any MA client who requests one. It describes the circumstances that support a claim and how to document a claim.

The client must sign and date the claim in the presence of an ES worker or a notary public. The client’s signature initiates the claim.

File the original in the case record, give the client a copy, and attach a copy to the referral document when a claim is made at application.

Send the CSA a copy of all other claims within two days after a claim is signed. When you inform the CSA of a claim, they will immediately suspend all activities to establish paternity or secure medical support until notified of your final determination.

3.3.5.3 Circumstances

The ESA or Social Service agency must determine whether or not cooperation is against the best interests of the child. They waive cooperation only if:

1. The client's cooperation is reasonably anticipated to result in physical or emotional harm to the:

a. **Child**. This means that the child is so emotionally impaired, that his or her normal functioning is substantially affected, or

b. **Client.** This means the impairment is of such a nature or degree that it reduces that person's capacity to adequately care for the child, or

2. At least one of the following circumstances exists and it is reasonably anticipated that proceeding to establish paternity or secure support or both would be detrimental to the child:

a. The child was conceived as a result of incest or sexual assault, **or**

b. A petition for the child's adoption has been filed with a court, **or**

c. The parent is being assisted by a public or private social agency in deciding whether or not to terminate parental rights and this has not gone on for more than three months.

3.3.5.4 Determination

The ESA or Social Services staff must determine whether or not there is good cause. This should be done within 45 days from the date a claim is signed. You may extend this if it is documented in the case record that additional time is necessary because:

1. The CSA cannot obtain the information needed to verify the claim within the 45 days, or

2. The client does not submit corroborative evidence within 20 days.

File the good cause determination and all evidence submitted in the case record. Include a statement on how the determination was reached.

If there is no evidence or verifiable information available that suggests otherwise, you must conclude that an alleged refusal to cooperate was, in fact, a case of cooperation to the fullest extent possible.

If the client is cooperating in furnishing evidence and information, do not deny, delay, or discontinue MA pending the determination.

If a Fair Hearing is requested on a good cause determination, continue any MA certification until the decision is given.

Do not use the 45-day period for determining good cause to extend an eligibility determination. The 30-day limit on processing an application is still a requirement.

The ESA must notify the applicant in writing of the final determination and of the right to a Fair Hearing. Send the CSA a copy. The CSA may also participate in any Fair Hearing.

3.3.5.5 Evidence

An initial good cause claim may be based only on evidence in existence at the time of the claim. There is no limit to the age of the evidence. Once a final determination is made, including any Fair Hearing decision, any subsequent claim must be based on new evidence.

The following may be used as evidence:

1. Birth certificates or medical or law enforcement records that indicate that the child may have been conceived as a result of incest or sexual assault.

2. Court documents or other records which indicate that a petition for the adoption of the child has been filed with a court.

3. Court, medical, criminal, child protective services, social services, psychological school, or law enforcement records which indicate that the putative father or absent parent might inflict physical or emotional harm on the client or the child.

4. Medical records which give the emotional health history and present

emotional health status of the client or the child.

5. A written statement from a mental health professional indicating a diagnosis of or prognosis on the emotional health of the client or the child.

6. A written statement from a public or private social agency that the agency is assisting the parent to decide whether or not to terminate parental rights.

7. A sworn statement from someone other than the client with knowledge of the circumstance on which the claim is based.

8. Any other supporting or corroborative evidence.

When a claim is based on emotional harm to the child or the client, the ESA must consider the:

1. Person's present emotional state, and

2. Person's emotional health history, and

3. Intensity and probable duration of the emotional impairment, and

4. Degree of cooperation required, and

5. Extent of the child's involvement in the paternity or the support enforcement activity to be undertaken if the client submits only one piece of evidence or inclusive evidence, you may refer him/her to a mental health professional for a report relating to the claim.

When a claim is based on his/her undocumented statement that the child was conceived as a result of incest or sexual assault, you may review it as one based on emotional harm.

The ESA must conduct an investigation when a claim is based on anticipated physical harm and no evidence is submitted.

The client has 20 days, from the date the claim is signed, to submit evidence. The ES or social services staff may, with supervisory approval, determine that more time is needed.

There must be at least one document of evidence, in addition to any sworn statements from the client.

Encourage the provision of as many types of evidence as possible and offer your assistance in obtaining necessary evidence.

When insufficient evidence has been submitted:

1. Notify the client of this and specify the evidence needed, and

2. Advise that person on how to obtain the evidence, and

3. Make a reasonable effort to obtain specific documents that are not reasonably obtainable without assistance.

If the client continues to refuse to cooperate or the evidence is still insufficient, notify him/her of this. State in the notice that if no further action is taken within ten days from the notification date, good cause will not be found and that s/he may first:

1. Withdraw the claim and cooperate, or

2. Exclude allowable individuals, or

3. Request a hearing, or

4. Withdraw the application or request that the case be closed.

When the ten days have expired and no option above has been taken:

1. Deny MA to the applicant or remove the recipient from the MA card, and

2. Provide MA without regard to the client's needs, to the eligible child(ren).

The sanctions remain in effect until there is cooperation or until it is no longer an issue.

3.3.5.6 Investigation

The ESA must investigate all claims based on anticipated physical harm both when the claim is credible without corroborative evidence and when such evidence is not available. Good cause must be found when both the client's statement and the investigation satisfy you that s/he has good cause.

You may investigate any claim when the client's statement together with any corroborative evidence does not provide a sufficient basis for a determination.

In the course of the investigation, neither the ESA nor the CSA may contact the absent parent or putative father without first notifying the client of your intention. You must also notify him/her and s/he has ten days from the notification date to:

1. Present additional supporting or corroborative evidence of information so that contact is unnecessary, or

2. Exclude allowable individuals, or

3. Withdraw the application or request that the case be closed, or

4. Request a hearing.

When the ten days have expired and no option has been taken:

1. Deny MA to the applicant or remove the recipient from the MA card, and

2. Provide MA, without regard to the client's needs, to the eligible child(ren).

The sanctions shall remain in effect until there is cooperation or until it is no longer an issue.

3.3.5.7 Good Cause Found

When good cause is found, the ESA must direct the CSA to not initiate any or to suspend all further case activities.

However, when the CSA's activities, without the client's participation are reasonably anticipated to not result in physical or emotional harm, the ESA must:

1. First notify the person of the determination and the proposed directive to the CSA to proceed without his/her participation.

2. S/he has ten days from the notification date to:

   a. Exclude allowable individuals, or

   b. Request a hearing, or

   c. Withdraw the application, or request that the case be closed.

3. At the end of the ten days, direct the CSA to proceed if no option was taken. The CSA may decide to not proceed based on its own assessment.

The ESA's determination to proceed without the client's participation must be in writing. Include your findings and the basis for the determination. File it in the case record.

3.3.5.8 Good Cause Not Found

When good cause is not found, the ESA must notify the client. Also state in the notice that s/he has ten days from the notification date to:

1. Cooperate, or
2. Exclude allowable individuals, or
3. Request a hearing, or
4. Withdraw the application or request that the case be closed.

When the ten days have expired and if no option has been taken:

1. Deny MA to the applicant or remove the recipient from the MA card, **and**

2. Provide MA, without regard to the applicant or recipient's needs, to the eligible child(ren).

The sanctions remain in effect until there is cooperation or until it is no longer an issue.

3.3.5.9 Review

The ESA does not have to review determinations based on permanent circumstances. Review those based on circumstances subject to change at review and when there is new evidence.

Notify the recipient when you determine that good cause no longer exists. Also state in the notice that s/he has ten days from the notification date to:

1. Cooperate, **or**
2. Exclude allowable individuals, **or**
3. Request that the case be closed, **or**
4. Request a hearing.

When the ten days have expired and if no option has been taken:

1. Remove the recipient from the MA card, and
2. Provide MA, without regard to the recipient's need, to the eligible child(ren).

The sanctions remain in effect until there is cooperation or until it is no longer an issue.

This page last updated in Release Number : 02-04
Release Date: 10/01/2002
Effective Date: 10/01/2002

3.3.6 Health Insurance

Collect health insurance information on both the custodial and absent parent using CARES. EDS also populates health insurance information to CARES. Only use the Health Insurance Information form (HCF 10115) as a backup to CARES.

This page last updated in Release Number : 02-04
Release Date :10/01/02
Effective Date :10/01/02

3.3.7. Cooperation Between ESA & CSA

The relationship between the ESA and the CSA is an ongoing cooperation.

3.3.7.1 Information

The ESA provides the CSA with information vital to opening medical support cases. The ESA also supplies continuing information, which assists them in providing medical support services. Therefore, the CSA may request information from the ESA in addition to that included in the referral and as contained in the case record.

CARES automatically shares client information with KIDS so it is important to enter the data accurately.

3.3.7.2 MA Discontinued

The CSA is notified through CARES when MA is discontinued.

3.3.7.3 Failure to Cooperate

The CSA will determine if non-cooperation occurs. KIDS notifies CARES if the client refuses or fails to cooperate. You must then review eligibility.

3.3.7.4 Fraud

When the CSA has knowledge of possible fraud, they will refer the case back to you. For example, if in the process of collecting support the CSA establishes that a parent is in fact not absent, they will give you that information for appropriate action (IMM, Ch. II, Part D, Fraud).

This page last updated in Release Number: 02-04
Release Date: 10/01/02
Effective Date: 10/01/02

3.4 STRIKER

3.4.1 Striker Defined

A striker is anyone who participates in: (1) a strike or concerted stoppage of work by employees, or (2) any concerted slowdown or other interruption of operations by employees.

A person is a striker whether or not s/he personally voted for the strike. Consider a striker to be on strike until s/he actually returns to work.

3.4.1.1 Lockout

If a person is not going to work because the company has imposed a lockout, do not consider him/her a striker.

3.4.1.2 Unemployment Compensation

If a person is receiving unemployment compensation, do not consider him/her a striker.

This page last updated in Release Number : 01-00
Release Date: 01/01/00
Effective Date: 01/01/00

3.4.2 POLICY

With the following exceptions, the striker and anyone in the fiscal group for whom s/he is legally responsible is ineligible for MA.

Being on strike isn't good cause for leaving employment or refusing to seek or accept employment.

3.4.2.1 Exceptions

Do not determine the following to be ineligible for MA, even if s/he or someone in his/her fiscal group is a striker:

1. Minor children.
2. Pregnant woman who is otherwise eligible for MA and MA/Healthy Start.
3. Anyone eligible for an MA Extension.
4. Anyone 65 years of age or older.
5. Anyone who is blind.
6. Anyone who is disabled.

Family Nonfinancial

3.5 CARETAKER

3.5.1 RELATIONSHIPS

3.5.1.1 Adult

An adult is anyone age 18 or older.

3.5.1.2 Child

A child is a person who is someone's natural or adoptive son or daughter. A child may be of any age, and may be either married or unmarried.

3.5.1.3 18-Year-Old

An 18-year-old is non-financially eligible for MA. Marital status has no effect on his/her nonfinancial eligibility. Nor is it necessary that the 18-year-old be under the care (3.5.3) of a caretaker (3.5.2) or be classified as a dependent 18-year-old.

Anyone age 18 is a dependant 18 year-old if s/he is:

1. Classified as a full-time student in high school, or in the equivalent level of vocational or technical training and reasonably expected to complete the program before age 19. **or**

2. Carrying sufficient credits to be reasonably expected to graduate or get a GED before reaching age 19. If s/he is, for example, carrying only 3 credits, but only needs 3 credits to graduate, s/he is a full time student.

3.5.1.4 Minor

A minor is a person less than age 18. A minor is nonfinancially eligible for MA. Marital status has no effect on his/her nonfinancial eligibility. Nor is it necessary that the minor be under the care (3.5.3) of a caretaker (3.5.2).

3.5.1.5 Child-In-Common

A child-in-common is a minor or never married dependent 18-year-old living in a household with both of his/her natural and/or adoptive parents.

3.5.1.6 Stepchild

A stepchild is a minor or never married dependent 18-year-old living in a household with the spouse of one of his/her parents. That spouse is not his/her other natural parent.

A stepchild remains a stepchild even if his/her natural parent is not in the household, as long as the stepparent is still in the household.

3.5.1.7 Non-Legally Responsible Relative (NLRR) Child

A non-legally responsible relative (NLRR) child has no relatives in the household who are legally responsible for him/her. S/he meets these two conditions:

1. S/he does not have a parent or stepparent in the household.

2. The primary person, the primary person's spouse, or a nonmarital parent is his/her caretaker.

A stepchild is not a NLRR child.

3.5.1.8 Full Sibling

A person's brother or sister, with whom s/he shares both parents, is a full sibling.

3.5.1.9 Half Sibling

A person's brother or sister, with whom s/he shares only one parent, is his/her half sibling.

3.5.1.10 Legally Responsible Relative (LRR)

A legally responsible relative (LRR) is a person who is legally responsible for another person Spouses are legally responsible for each other. Parents are legally responsible for their minor children.

3.5.1.11 Spouse

A spouse is that person recognized by Wisconsin law as another person's legal husband or wife. Wisconsin does not recognize common law marriage.

3.5.1.12 Parent

A parent is any natural or legally adoptive mother or father. A parent can be any age. There can be more than one parent of a certain gender in a household.

3.5.1.13 Stepparent

A stepparent is the spouse of a child's parent by a later marriage.

Once s/he becomes a stepparent through marriage, s/he remains a stepparent, even if his/her spouse is absent from the household due to death, divorce, or separation.

3.5.1.14 Non-Marital Co-Parent (NMCP)

A non-marital co-parent (NMCP) parent of a child-in-common, in a household where both of the following are true:

1. S/he lives with, but is not married to the primary person, and

2. The primary person is the other parent of the child-in-common.

3.5.1.15.1 Claimed Father

Paternity has not been established. A claimed father is not the father for MA eligibility purposes and should be referred to the Child Support Agency (CSA).

3.5.1.15.2 Acknowledged Father

An acknowledged father is someone that has not been adjudicated, but fits one of the following criteria:

1. Filed paternity papers, **or**
2. Has his name on the birth certificate.

An acknowledged father is the father for MA eligibility purposes. Do not refer acknowledged fathers to the CSA.

3.5.1.15.3 Adjudicated Father

The adjudicated father is the legal father. Include him in all eligibility determinations for the child if he is living in the household. Do not refer adjudicated fathers to the CSA.

3.5.1.16 Minor Parent

A minor parent is a minor who:

1. Is not the primary person, and
2. Is living in a household where the primary person is his/her LRR caretaker, and
3. Has his/her own child under his/her care.

This page last updated in Release Number : 04-03
Release Date : 07/01/04
Effective Date : 07/01/04

3.5.2 CARETAKER

A caretaker is anyone who is the child's:

1. Naturally or legally adoptive parent.

2. Stepfather or stepmother.

3. Natural full brother or sister, legally adopted, half- or stepbrother or sister.

4. Grandmother or grandfather, aunt or uncle, first cousin, nephew or niece, or any preceding generation denoted by the prefix grand-, great-, or great-great, and including those through adoption.

5. Spouse of any of the above even after the marriage ends by death, divorce, or separation.

3.5.2.1 Parental Rights Terminated

A parent whose parental rights have been legally terminated is not a caretaker.

3.5.2.2 Annulment

The annulment of a marriage removes all relationships established by the marriage except parent.

3.5.2.3 Non-Legally Responsible Relative (NLRR) Caretaker

A non-legally responsible relative (NLRR) caretaker is a caretaker who has no legal responsibility for the minor or 18 year-old under his/her care.

This page last updated in Release Number : 02-01
Release Date :01-01-02
Effective Date :01-01-02

3.5.3 UNDER THE CARE

A minor or dependent 18-year-old is under the care of a person when the person:

1. Is a caretaker, and

2. Exercises primary responsibility for the child or dependent 18-year-old's care and control, including making plans for him/her. Once a minor marries, s/he no longer can be under the care of a caretaker relative.

3.5.3.1 Legal Custody

Unless a court has transferred custody to someone else, assume that the child's parents have legal custody of their child.

If a child lives simultaneously with both an NLRR and an adult LRR, the child is under the care of the relative who is living with the child and who has legal custody of the child.

Example: Alice, age six, and her mother, Jane, live with Jane's parents. The grandparents have legal custody of Alice. Alice is considered to be under the care of her grandparents, not of her mother.

If a child lives with his/her parent(s), but legal custody has been transferred to someone else who is not living with them, the child (with one exception) is under the care of his/her parent(s). For the exception, see 3.5.3.2 Joint Custody below.

3.5.3.2 Joint Custody

When the natural or adoptive parents of a child do not live together, and have joint custody (through a mutually agreed upon arrangement or court order), act on the Family MA case as follows:

1. Determine if the agreement or court order awarding joint custody designates a "primary caretaker." A parent designated as the primary caretaker is the primary person.

2. If one parent is not designated, ask the parents to decide which one is the "primary caretaker." If they decide within the 30-day processing, act on the application as based on what they decided.

3. If no decision is made within the 30 days of the application date, review the parents' activities and responsibilities to determine which parent is the primary caretaker. Use the list below:

   a. If the parents reside in different school districts, where does the child attend school? Who selected the school?

b. Who assists the child with homework or school-related tasks?

c. Are there tuition costs for the child's education? If so, who pays those costs?

d. If the child is enrolled in day care, who arranges for and pays these costs?

e. Who is responsible for taking the child to and from school and/or day care?

f. Which parent is listed as the contact for emergencies at the child's school or day care provider?

g. Who arranges medical and dental care for the child? Who selects the physician and dentist? Who maintains the child's medical records?

h. Who initiates decisions regarding the child's future?

i. Who responds to medical or law enforcement emergencies involving the child?

j. Who spends money on food or clothing for the child when the child visits the absent parent?

k. Who disciplines the child?

l. Who plays with the child and arranges for entertainment?

m. Are more of the child's toys, clothing, etc., kept at one parent's home than the other's?

This list is not exclusive, and there may be situations where you find additional criteria to apply.

There are cases in which these questions may be answered positively for both parents. However, in reviewing parental responsibilities and roles, usually you will find one parent more often identified. Identify this parent as the primary person for determining eligibility.

Document your decision in the case record.

This page last updated in Release Number : 02-01
Release Date :01-01-02
Effective Date :01-01-02

3.5.4 ESSENTIAL PERSON

An AFDC-Related MA Family MA group is limited to:

1. A dependent child(ren), and

2. A natural parent, or adoptive parent(s), or one NLRR, and

3. Essential persons.

Only ES agency staff in positions or with authority higher than a first line ES Worker may approve, deny, and review any essential person designation. Reviews must occur at least every six months.

When a child is under the care of the spouse of a stepparent (when there's no eligible child-in-common) or NLRR, the other spouse can be included in the MA group only if s/he is an essential person. Only a caretaker who has a child under his/her care may designate an essential person.

To designate an essential person, the caretaker fills out the Designation of an AFDC-Related Essential Person form and submits it to the ES agency. S/he must document the need for each essential person and that the person can provide the essential service.

Example: Carl, age 2, lives with his mother and stepfather. There is no child-in-common. Although both the mother and stepfather are caretakers, only the mother may have Carl under her care. To include the stepfather in the MA group, the mother must designate him as an essential person.

Carl next moves in with his aunt and uncle, and is under his aunt's care. To include the uncle in the MA group, the aunt must designate him as an essential person.

Final approval rests with the ES agency.

More than one person may be designated as an essential person in the same MA group, but only for different children. No one, however, may be an essential person in more than one MA group. Also, there can be no essential person if there is no born child, as in a Maternity Care case.

To be included in an AFDC-Related MA group as an essential person, the designated person must:

1. Be related to an AFDC-Related MA group member.

2. Be otherwise nonfinancially eligible, except that the essential person need not have a minor or dependent 18-year-old under his/her care.

3. Provide at least one of the following to another MA group member:

   a. Child care that enables a caretaker to:

      - Work outside the home, full time (30 hours or more a week), for pay,

      - Receive training full time (30 hours or more a week),

      - Attend HS or GED classes full time (as defined by the school).

   b. Care for anyone who is incapacitated.

      Consider a parent incapacitated if, due to physical, emotional, or mental impairment, s/he cannot:

      - Work full - time at employment paying at least Federal minimum wage, or

      - Perform customary, necessary homemaking activities or provide adequate care for his/her children without help from other persons.

      If the applicant claims s/he is incapacitated and cannot work full-time at employment paying at least Federal minimum wage, do the following:

      Give him/her the Medical Examination and Capacity Form (DES 2012). Instruct him/her that it must be completed by a medical professional.

This page last updated in Release Number : 04-03
Release Date :08-02-04
Effective Date :08-02-04

3.5.5 MOVES

When a child moves from the home of a caretaker who was eligible for AFDC-Related MA for that month to the home of another caretaker who applies for AFDC-Related MA in the same month, the new caretaker can be eligible as of the application date. The child, however, isn't eligible in the new household until the 1st of the month after the move.

This page last updated in Release Number : 02-01
Release Date:01-01-02
Effective Date:01-01-02

3.5.6 TEMPORARY ABSENCE

A child and that child's caretaker can be in the same AFDC- Related or AFDC-MA group even when not living together if either is temporarily absent, provided:

1. The continuous absence is expected to be for no more than six months.

   The ES agency may approve an extension of a child's temporary absence beyond six months when there is a written plan that demonstrates that the intent is to return the child to the caretaker's home, and

2. The child’s care is not reimbursable by the Title IV-E program (Federal Foster Care), and

3. The caretaker continues to exercise responsibility for the care and control of the child.

   A child may be considered temporarily absent, and remain in the caretaker's AFDC-Related or AFDC-MA group, when s/he is placed in non-Title IV-E Foster Care, Kinship Care, or a group home.

   Children who are inmates of public institutions (5.8.1) are not temporarily absent.

   Children who are placed in an institution for 30 or more days are not temporarily absent, unless they were placed there by a child welfare agency.

   Children who are placed in an IMD are not temporarily absent, unless they were placed there by a child welfare agency.

3.5.6.1 Exceptions

If the child is removed under a dispositional order meeting the following criteria, s/he is ineligible under the temporary absence policy.

For AFDC-MA, if the child's absence is the result of removing the child under a dispositional order which places the physical custody of the child outside of the home for three months or more. This includes an order for an indefinite period.

For AFDC-Related MA, if the child’s absence is the result of removing the child under a dispositional order:

1. Placing the physical custody of the child outside of the home (for any duration), and

2. The caretaker doesn’t participate in a permanency plan developed by the child welfare agency whose goal is the reunification of the family.

3.5.6.2 Non-Legally Responsible Relatives (NLRR) Caretakers

Non-Legally Responsible Relatives (NLRR) of children placed in their homes may be eligible for MA as a caretaker of a deprived child. This would include children receiving Kinship Care. If the child is temporarily absent from his/her parent’s home, an NLRR wouldn't be eligible for MA as the caretaker of the child. Both the NLRR and the parents can’t be considered to be providing care. Under the temporary absence policy, the parents are still the children’s caretaker while the children are temporarily absent.

3.5.6.3 Processing

The process to certify temporarily absent children is not in CARES. You can either do overrides in CARES or by completing and returning a HCF 10110 (formerly DES 3070). Completed HCF 10110s may be returned by:

1. Mail: EDS
   P.O. Box 7636
   Madison, WI 53707

2. E-mail: eds_3070@dhfs.state.wi.us

3. Fax: (608) 221-8815

If a caretaker informs you that his/her child has been placed outside of the home under a dispositional order, ask who their caseworker is. The caseworker will verify
the:

1. Child is not IV-E eligible, and

2. The caretakers continue to participate in a child welfare agency developed plan whose goal is reunification of the family.

3.5.6.4 Caretakers

Caretakers must meet eligibility under the AFDC-Related Categorically Needy criteria to receive MA. The child must be deprived due to the absence, incapacity or unemployment of a parent.

Determine eligibility for the caretaker as if the child is in the home. Count the income of the child. Do not count child support or any foster care payments provided by the caretakers you are determining eligibility for. If found eligible, certify the caretaker manually using a 3070 with a Med Stat code of "AM."

Certify temporarily absent children separately from their caretaker.

3.5.6.5 BadgerCare

See 5.7.5.9

This page last updated in Release Number : 05-01
Release Date: 01-11-05
Effective Date: 01-11-05

3.5.7 HUBER LAW

Huber Law prisoners who are released from jail for the purpose of attending to the needs of their families can become eligible for Medicaid. If the other parent is continuously absent, the Huber law prisoner may be the caretaker (3.5.2) in the household if the prisoner.

1. Intends to return to the home,
2. Continues to be involved in the planning for the support and care.

Huber Law prisoners who are released for a purpose other than attending to the needs of their families are not eligible for Medicaid. Consider them to be absent parents.

Absent parents. A child is deprived of parental (mother or father or both) care or support when a parent is continuously absent from the home:

1. Due to the parent's death, divorce, legal separation, annulled marriage, abandonment, institutionalization, or incarceration (prison or jail).
2. For any other reason except military service. "Any other reason" means:,

a. The parent's absence interrupts or ends his/her parental role of provider of maintenance, physical care, or guidance to the child, and

b. The known or indefinite length of the absence is such that s/he can't be counted on for planning the child's present support of care.

This page last updated in Release Number : 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

EBD NONFINANCIAL

3.6 WHO IS DISABLED?

3.6.1 DETERMINATION OF DISABILITY

An individual who is blind or disabled is non-financially eligible. (1.1.1.2). Disability and blindness determinations are made by the Disability Determination Bureau (DDB) in the Department of Health and Family Services. The Economic Support Agency (ESA) should submit an application for a disability determination even if the client has already applied for SSI or SSDI. Send applications, medical reports and releases to:

Regular Mail
Disability Determination Bureau
P.O. Box 7886
Madison, WI 53707-7886

Certified Mail
Disability Determination Bureau
722 Williamson Street
Madison, WI 53703-3546

A DDB disability decision on a SSDI or SSI case generally has binding authority. A Medicare or SSDI disability certification notice is acceptable verification of disability.

To check on the status of a disability case, call (608) 266-1565 and DDB will connect you with the examiner assigned to the case. Direct procedural or policy questions to Terri Klubertanz at (608) 266-7604.

Pend the case in CARES while you are waiting for a disability decision from DDB. Go to ANDI and enter a "?" in the disability verification field. Extend the date on AGVC and send a manual notice telling the client that eligibility is pending the disability decision. Remind him/her to report any changes within 10 days.

3.6.1.1 Definition of Disability

The law defines disability for Medicaid (MA) as: 'The inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.' Substantial gainful activity is currently defined as gross income of $800 or more per month. See 3.6.9 for the Medicaid Purchase Plan (MAPP) disability definition.

This page last updated in Release Number : 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

3.6.2 Application Process

3.6.2.1 Information Form

Give an Information for Medicaid - Disability Applicants form (HCF 10112) to each person applying for MA Disability.

3.6.2.2 Application Form

Give each applicant a Medicaid-Disability Application form (HCF 10112).

Make sure the form is filled out completely with names and addresses of all medical sources that have treated the applicant.

Applicants must list **all** of their medical problems.

An applicants' employment background is important in determining disability in most cases. The more information you can provide the better. DDB must have a 15-year work history. Detailed information about current work is necessary in all cases.

DDB may consider a medical onset of disability date going back to the first of the month, three months prior to the date of the signed application.

3.6.2.3 Release Form

Ask the applicant to sign a Confidential Information Release Authorization – Release to Disability Determination Bureau form (HCF 14014) for each medical source identified on the application form plus several additional copies. (Some hospitals and institutions require a release for each department.) **This is the only form DDB can accept.**

Leave the box blank that asks for the “Name and Address – Agency/Organization Authorized to Release Information.” DDB has scanners that will automatically fill in the blank. Filling it in creates problems for them.

Applications for disability made by the applicant must include releases that are signed personally by the disabled applicant. Applications made on behalf of a disabled applicant must be accompanied by release forms signed by a legally appointed representative. A copy of the court order appointing a representative must be included with the application. An authorized representative's signature on the release is not acceptable unless s/he has a court order.

3.6.2.4 Medical Report

A medical report of disability does not need to be submitted with the application. DDB will obtain all of the medical reports necessary for the disability determination.

If the applicant has copies of any medical records, school records, etc., include them with the application. See 3.6.1 for the DDB address.

Applications that are not fully completed with names and addresses and work information will be returned to the local ESA.

3.6.2.5 SSI Application Date

Occasionally a person applies for SSI and is determined ineligible for SSI payments. In these cases, determine MA eligibility from the SSI application date, if it is earlier than the ES application date.

An application for SSI is also an application for MA.

S/he must still meet all MA eligibility requirements. You must request the SSI application date by using the state on line query (SOLQ).
Use the SSI application date as the filing date if the client contacts the ESA within the calendar month following the month of the SSI denial. If the contact to the ESA is later than the above, the filing date is the regular date s/he applied at the ESA.

3.6.2.6 Routine SSI-MA Extension

The ESA fills the gap in eligibility between the loss of SSI-MA and an eligibility determination by the ESA. Certify the client for the period between the loss of SSI-MA eligibility that appears on MMIS and when you will be able to determine their MA eligibility. Determining MA eligibility should usually occur within the month after s/he loses SSI.

When a person applies for SSI and is denied, there is no obligation to "fill gaps." The exception to this is in 3.6.2.5.

The ES agency will fill the gap in eligibility when an ongoing SSI case is terminated. The person is eligible for a re-determination of MA eligibility by the ESA. S/he should apply within the calendar month of notification of termination. An extra month of SSI-MA eligibility is posted on MMIS to allow the client time to have eligibility determined by the ESA.

There is no fill the gap provision for those who lose their SSI eligibility because of:

1. Death
2. Leaving Wisconsin
3. Incarceration
4. Fleeing drug felon

3.6.2.6.1 Case Processing

The processes differ based on if the client is already open for another program in CARES or if they aren't open in CARES. The starting point for both CARES and non-CARES cases is an MMIS and SOLQ query.

Active CARES cases- An active case in CARES is one in which the person is part of a case where at least one person is currently open, or closed less than 30 days for at least one program of assistance. If the client has an active case in CARES, EDS sends a list to the agency's CARES coordinator of those losing SSI and sends those clients a letter saying the ES worker will contact them if there isn't enough information to determine eligibility.

As soon as the ES worker receives the list of those in active CARES cases, s/he:

1. Opens the client for MA in CARES. This may seem unusual since s/he will show eligibility on MMIS for a grace month. The reason you open all of them in CARES is to provide a tracking mechanism to show you "filled the gap" and that the client receives the correct notice, if s/he fails eligibility later. CARES instructions are:

    a. ACPA- Request MA
    b. ANBR- Change the Y in the SSI field to N or on ANBC – change the Y in the 1619(b) field to N.
    c. Don't change any financial information (unless you need to in order to make the person eligible).
    d. Complete any other required demographic information.
    e. Verifications aren't required at this point.
    f. Run eligibility and confirm.

2. The day after you open the case, request verification of any items you need to determine continued MA eligibility. At this point, treat the case as a regular case, and all verification rules, etc. apply. The client has 10 days to provide verifications.

Non CARES- If the client doesn't have an active case on CARES, EDS sends a letter along with an application telling him/her that s/he must apply.

The client sends the application to EDS and EDS forwards it to the CARES coordinator, who assigns it to a worker. The worker enters the case and determines eligibility. MMIS will close those cases that do not send an application within 30 days of their request.

3. Reminder: For all cases, (CARES and Non-CARES) even if the client doesn't meet MA eligibility requirements for the months between when s/he lost SSI and when you are re-determining eligibility, s/he is still eligible. Don't require the client to come into the office. Ineligibility starts, following timely notice, when s/he:

   a. Does not return the application (EDS takes care of this, **or**
   b. Fails to respond to an information request, **or**
   c. No longer meets eligibility requirements (only forward from when the review or application is done).

3.6.2.7 Other SSI-MA Extensions

Fill the gap between the loss of SSI-MA and an eligibility determination by the ESA when:

1. Retroactive SSI approval and termination occurs. A person applies for SSI and is approved. The approval is retroactive and the SSI also is terminated retroactively.

2. Eligibility for MA is not determined timely by the ESA through no fault of the client.

This page last updated in Release Number : 03-01
Release Date:01/01/03
Effective Date: 01/01/03

3.6.3. DDB Action

DDB will attempt to process the disability determination within 60 days of the date it receives the signed application. If a delay in processing the application occurs because the extent of an impairment will not be known until several months after its onset, DDB will notify the applicant in writing that additional evaluation time is necessary. DDB will give the reason for the delay and will inform the person of the right to appeal the delay. The ESA will receive a copy of the letter.

3.6.3.1 Diary Date

Item 17 on the SSA-831 form indicates whether or not medical re-examination is required for recipients not on SSI or SSDI. An exam is required when improvement is expected to occur in a person's condition. A date on the box to the right of item 17, "Diary Type", tells you when DDB wants to review the case again. When the Diary Date is earlier than the current date refer to the instructions that follow under Redetermination (3.6.6).

3.6.3.2 Allowances

Files on persons found disabled will be returned to the ESA with a completed SSA-831 Determination of Disability.

3.6.3.3 Denials

Persons found not disabled will be sent a notice by DDB (a copy will be sent to the ESA) along with forms to apply for a Reconsideration/Hearing. Files on denied cases will be kept at DDB for 60 days. If the ES agency needs a file after 60 days, call Robin Kast at (608) 266-3300 and the files will be returned to the ESA.

This page last updated in Release Number : 05-01
Release Date: 01/11/05
Effective Date: 01/11/05

3.6.4 Reconsideration/Hearing

Send Reconsideration/Hearing requests to:

Disability Determination Bureau
Medicaid Reconsideration Unit
P.O. Box 7886
Madison, WI 53707-7886.

Requests for Reconsideration/Hearing must be received by DDB within 45 days of the date of the Denial Notice.

DDB will conduct a reconsideration of the denial. If DDB reverses the decision to an allowance, the determination and folder will be sent to the ESA.

If DDB affirms the denial, a Reconsideration Denial notice will be sent to the applicant (a copy will be sent to the ESA) and the file will be sent directly to the Division of Hearings and Appeals, which will then schedule a hearing.

If, in a fair hearing, a person is found to be disabled, and the hearing officer does not specify a date for review, contact DDB and request a date to review the disability.

This page last updated in Release Number : 02-03
Release Date: 07/01/02

3.6.5 Medical Exam Cost

If the person's MA application is approved, MA will pay the cost of any medical examination necessary for the completion of a current medical report. If it is denied, you may claim the cost of the examination as an administrative expense. Reimbursement is from the MA administrative account.

This page last updated in Release Number: 02-03
Release Date: 07/01/02
Effective Date: 07/01/02

3.6.6 Redetermination

Review a disability determination when:

1. The Disability Determination and Transmittal (SSA-831) indicates medical re-examination in item 17 of that form, **or**
2. The person no longer receives OASDI (Social Security) disability benefits, **or**
3. The medical circumstances have significantly improved, **or**
4. The person has returned to work.

Complete and/or forward the following to DDB:

1. MA Disability Redetermination Report.
2. Signed Confidential Information Release forms. See 3.6.2.2.
3. The original Disability Determination form (SSA-831) and any subsequent disability determinations and all prior medical evidence and forms.

DDB will make a decision, which will be indicated on a Cessation or Continuance of Disability form (SSA-833).

Item 9 (SSA-833) indicates the decision of (A) continuing, or (B) ceased.

Item 23B (SSA-833) indicates a medical re-examination date when necessary.

This page last updated in Release Number : 02/03
Release Date: 07/01/02
Effective Date: 07/01/02

3.6.7 Conflicting Claims

Disability determinations for Social Security, SSI and Medicaid are completed under the same regulations. DDB's decisions will be consistent if the person files for any of these programs. If a decision on one program is later changed by appeal or because of new evidence, etc., DDB will notify the other program's to change their determinations to match.

DDB may request return of MA disability files when reviews of conflicting or updated decisions are needed.

This page last updated in Release Number: 01-04
Release Date: 07/01/01
Effective Date: 07/01/01

3.6.8 Presumptive Disability

Federal SSI law and regulations state that the SSI program can find an individual to be presumptively disabled and will be treated as a person with a disability until a final disability determination can be completed. To be treated as presumptively disabled by SSI means that the applicant's benefits can begin before SSA, or its contracted agency, has formally determined the individual to be disabled.

Wisconsin's Medicaid program also allows a detemination of presumptive disability.

Presumptive Disability (PD) is a method for authorizing emergency MA coverage prior to a formal disability determination by DDB. Presumptive disability is determined either by the DDB, or in some circumstances, by the Economic Support worker. The regular disability application process (3.6.2) must still be completed for persons with a presumptive disability. A presumptive disability decision stands until the DDB makes its final disability determination.

3.6.8.1 PD DETERMINED BY THE ECONOMIC SUPPORT WORKER

When a client has an urgent need for medical services attested to in writing by a medical professional, and is likely to be found disabled by DDB because of an apparent impairment, the client may be certified as presumptively disabled by the Economic Support worker.

In determining that the applicant is presumptively disabled, the Economic Support worker will need a "medical professional" to attest in writing that:

1. The individual's circumstances constitutes an urgent need (3.6.8.1.1) for medical services, and

2. The individual has one of a certain set of impairments (3.6.8.1.2).

A "medical professional" is defined as any health care provider or health care worker who is familiar with the applicant and is qualified to confirm the presence of an ‘urgent need’ and the presence of one of the impairments. (A medical professional is a licensed physician, physician’s assistant, nurse practitioner, licensed or registered nurse, psychologist, osteopath, podiatrist, optometrist, hospice coordinator, medical records custodian, or social worker.)

3.6.8.1.1 DEFINITION OF URGENT NEED

A person must be in one of the following situations to be considered to have an urgent need:

1. The applicant is a patient in a hospital or other medical institution; or
2. The applicant will be admitted to a hospital or other medical institution without immediate health care treatment; or
3. The applicant is in need of long-term care and the nursing home will not admit the applicant until Medicaid benefits are in effect; or
4. The applicant is unable to return home from a nursing home unless in-home service or equipment is available and this cannot be obtained without Medicaid benefits.

NOTE: In addition to health conditions of a physical nature, the above criteria may also apply to an urgent need resulting from an individual’s serious and persistent mental illness.

Example: An individual with schizophrenia who will need to be hospitalized if he or she does not take prescribed medication has an ‘urgent need’ if such medication is not available without Medicaid coverage.

3.6.8.1.2 IMPAIRMENTS

When an urgent need for medical services has been identified, the Economic Support worker can certify the client as presumptively disabled if the client has one of the following readily apparent impairments, as attested to in writing by a medical professional:

1. Amputation of a leg at the hip.
2. Allegation of total deafness.
3. Allegation of total blindness.
4. Allegation of bed confinement or immobility without a wheelchair, walker, or crutches due to a condition that’s expected to last 12 months or longer.
5. Allegation of a stroke (cerebral vascular accident) more than three months in the past and continued marked difficulty in walking or using a hand or arm.
6. Allegation of cerebral palsy, muscular dystrophy or muscle atrophy and marked difficulty in walking (e.g., use of braces), speaking, or coordination of the hands or arms.
7. Allegation of Down’s syndrome.

8. Allegation of severe mental deficiency made by another individual filing on behalf of a claimant who is at least seven years of age. For example, a mother filing for benefits for her child states that the child attends (or attended) a special school, or special classes in school, because of mental deficiency or is unable to attend any type of school (or if beyond school age, was unable to attend), and requires care and supervision of routine daily activities. Note: 'Mental deficiency' means mental retardation. This category pertains to individuals whose dependence upon others for meeting personal care needs (e.g., hygiene) and in doing other routine disability activities (e.g., fastening a seat belt) grossly exceeds age appropriate dependence as a result of mental retardation.
9. A physician or knowledgeable hospice official (hospice coordinator, staff nurse, social worker or medical records custodian) confirms an individual is receiving hospice services because of a terminal condition, including but not limited to terminal cancer.
10. Allegation of spinal cord injury producing inability to ambulate without the use of a walker or bilateral hand-held devices for more than two weeks, with confirmation of such status from an appropriate medical professional.
11. End stage renal dialysis confirmed by a medical professional.
12. The applicant's attending physician states the applicant will be unable to work or return to normal functioning for at least 12 months or the condition will result in death within the next 12 months.
13. The client has a positive diagnosis of HIV with other serious health conditions and will be unable to work or return to normal functioning for at least 12 months or the condition will result in death within the next 12 months.

3.6.8.1.3 PD CERTIFICATION PROCESS

A medical professional must complete and sign the Medicaid Presumptive Disability form (HCF 10130) attesting to both the urgent need and the impairment, before an Economic Support worker may certify the applicant as presumptively disabled. The worker should not require any additional documentation from the medical professional beyond the Medicaid Presumptive Disability form. Once completed, place a copy of this form in the case file to document the Medicaid Presumptive Disability decision. If the applicant is otherwise eligible for EBD Medicaid, certify Medicaid eligibility (see 3.6.8.4)

Once a presumptive disability decision has been made, the Economic Support worker must still follow the disability application process (3.6.2). The Medicaid Disability Application form (HCF 10112, formerly DES 3071) must be completed and sent to the DDB along with the necessary copies of the Confidential Information Release Authorization form (HFS-9). The DDB will then process the disability application and make a final disability determination.

3.6.8.2 PD DETERMINED BY DDB

If the applicant has an urgent need, but does not have one of the listed impairments, the Economic Support worker must request DDB to make a presumptive disability determination. The Economic Support worker must take the following actions once a medical professional has attested in writing, with the Medicaid Presumptive Disability form (HCF 10130), that there is an urgent need for medical services.

NOTE: If someone has an impairment, but not an urgent need, follow the normal disability application process (3.6.2).

1. Document the urgent need by placing the Medicaid Presumptive Disability form (HCF 10130) in the case file.

2. Complete, with assistance from the applicant as necessary, the following three forms:

   a. The Request for Medicaid Presumptive Disability Decision form (HCF 10125).
   b. The Medicaid Disability Application form (HCF 10112, formerly DES 3071).
   c. The Confidential Information Release Authorization form (HFS-9).

3. Send via fax (608-266-8297) each of the three forms listed above to DDB for both a presumptive and final disability determination. The FAX number is also on the request form (HCF 10125).

   DDB will make a presumptive disability finding on these cases and communicate their finding to the local Economic Support Agency within three business days of receiving the request for presumptive disability and the HCF 10112 form (not including the day the fax was received).

   Federal Regulations generally require the evaluation of certain disabilities after a three month period of recovery from the original injury or medical event (major head injuries, stokes, heart attacks, etc.) It may not be possible to establish disability, either on a presumptive or final basis during that period. However, all applications should be submitted and a complete medical review will be made.

3.6.8.3 DECEASED APPLICANTS

While a deceased person can be eligible for Medicaid in the months prior to his/her death, presumptive disability determinations are not allowed for individuals that are deceased. Process such requests for a final disability determination through the disability process through DDB.

3.6.8.4 ELIGIBILITY

PD-MA coverage begins on the date on which the presumptive disability finding is made by DDB or the ES worker.

Do not grant retroactive eligibility until DDB makes a formal disability determination, (when the case folder is returned to the ESA). Once DDB does the final determination, the case may be backdated up to three months prior to the month of application but no earlier than the date of disability onset, provided all other eligibility requirements are met.

3.6.8.5 DISABILITY APPLICATION DENIALS

3.6.8.5 1 DDB returns a negative Presumptive Disability decision

If the DDB returns a negative Presumptive Disability decision, the Economic Support worker must send a manual notice of decision to the applicant. The notice must state:

"Your request for Medicaid is based upon your statement that you are disabled. The final decision on your disability has not yet been made, however we have determined that you cannot be considered presumptively disabled. This means that you cannot be certified as eligible for Medicaid as a person with a disability until a final disability decision has been made. You will be informed when the Disability Determination Bureau makes the final disability decision. (Wis. Stats. ss. 49.46 and 49.47)"

3.6.8.5.2 Recipient ineligible for non-medical reasons

If a recipient is determined ineligible for non-medical reasons, you may terminate PD with timely notice without waiting for DDB's final disability decision. In such a case, notify DDB immediately at, (608) 266-1565, that a medical determination is no longer needed.

3.6.8.5.3 DDB reverse PD decision made by DDB or by the Economic Support Worker

If the DDB denies a disability application their decision reverses a PD decision made by the Economic Support worker or by DDB. Terminate Medicaid eligibility following timely notice requirements. (IMM, Ch. I). Medicaid eligibility based on a PD decision does not continue during the period a person is appealing DDB's decision that they are not disabled.

Benefits received while the disability decision was pending are not subject to recovery, unless the individual made misstatements or omissions of fact at the time of the presumptive disability determination.

This page last updated in Release Number: 05-01
Release Date:01/11/05
Effective Date: 01/11/05

3.6.9 MAPP

When a disability determination for the MAPP is required, complete the application process in 3.6.2 above.

Sections 12 and 13 of the Application for MA Disability form (HCF 10112) must be completed in full detail in all MAPP disability determination requests. Requests for a MAPP disability determination should be accompanied by a letter specifying whether the request is for a MAPP disability determination, or both a regular MA disability determination and a MAPP disability. It is advisable to have both determinations completed if an applicant may move from regular Medicaid disability to MAPP disability.

A determination of disability for MAPP excludes consideration of Substantial Gainful Activity (SGA), while a regular MA disability determination does not.

This page last updated in Release Number: 01-04
Release Date: 07/01/01
Effective Date: 07/01/01

3.7 WHO IS ELDERLY?

3.7.1 Elderly

3.7.1.1 Elderly Definition

An individual 65 years of age or older. An individual who is elderly is non-financially eligible. (1.1.1.2).

This page last updated in Release Number: 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

4 FINANCIAL REQUIREMENTS

4.1 INCOME

4.1.1 Introduction

Income is available when:

1. It is actually available, and
2. The person has a legal interest in it, and
3. The person has the legal ability to make it available for support and maintenance.

Examples of income sources that someone can make available are social security and unemployment compensation. This includes income increases such as Cost-of-Living Adjustments (COLAs).

When it is known that a member of the assistance group is eligible for some sort of income or an increased amount of income:

1. Count the income if the amount is known. Count it as if the person is receiving it.
2. Ignore the income if the amount is not known.

Example: Ms. M. is entitled to OASDI benefits of $450. However, she declined a $20 COLA increase, and her check is only $430. Since the full entitlement amount is known, available income is $450.

Income is unavailable when it will not be available for 31 days or more. The person must document that it will not be available for 31 days or more.

Unavailability is usually documented by a letter from an agency stating when the person will receive the benefit. Thus, if s/he has just applied for benefits, do not add it to his/her income yet. The income is not ignored; it is only suspended until it becomes available. Schedule an eligibility review for no later than the 60th day.

This page last updated in Release Number: 03-02
Release Date: 04-01-03
Effective Date: 04-01-03

4.1.2 Disregarded Income

“Disregard” means “do not count.” When you are calculating the total amount of income a person has received, disregard, that is, do not count, the following kinds of income:

4.1.2.1 Payments to Native Americans

Disregard the following payments to Native Americans:

1. Menominee Indian Bond interest payments.

2. All judgment payments to tribes through the Indian Claims Commission or Court of Claims.

3. Payments under the Alaskan Native Claims Settlement Act.

4. Payments under the Maine Indian Claims Settlement Fund.

5. Payments under PL 93-124 to the Sisseton-Wahpeton Sioux Tribe, except individual shares over $2,000.

6. Payments under PL 93-134 to the Maricopa Ak-Chin Indian Community, Navajo Tribe, Coast Indian Community of the Resighini Rancheria, Stillaguamish Tribe, Pueblo of Taos Tribe, Walker River Paiute Tribe, and White Earth Band of the Minnesota Chippewa Tribe, except individual shares over $2,000.

7. Payments under PL 94-114 to the Bad River Band and Lac Courte Oreilles Band of Chippewa Indians and the Stockbridge Munsee Indian Community of Mohicans.

8. Payments under PL 96-318 to the Delaware Tribe of Kansas and of Idaho.

9. Payments under PL 96-420 to the Houlton Band of Muliseet Indians, the Passamoquoddy, and Penobscot.

10. For EBD MA cases, under PL 98-64, disregard all Indian judgment funds held in trust by the Secretary of the Interior for an Indian tribe and distributed on an individual basis to members of the tribe. Also disregard interest and investment income from these funds.

11. Payments under PL 99-346, Saginaw Chippewa Indian T Tribe of Michigan.

12. Payments under PL 99-377 to the Mille Lacs, Leech Lake, and White Earth, MN, reservations.

13. Payments under PL 101-41, Puyallup Tribe of Indians Settlement Act of 1989.

14. Payments under the Distribution of Judgment Funds Act of 1987 to the Cow Creek Band, Umpqua Tribe.

15. Payments under the Distribution of Indian Judgment to the Crow Creek and Lower Brule Sioux except individual shares over $2,000.

4.1.2.2 Special Programs

Disregard income from all of the following:

1. Active Corp. of Executives (ACE).
2. Earnings of a census enumerator.
3. Emergency Fuel Assistance.
4. Foster Grandparents Program.
5. Governmental rent or housing subsidy, including reimbursements due to federal regulatory changes in computing HUD housing rent.
6. Homestead Tax Credit.
7. Low Income Energy Assistance Program.
8. Programs funded under Title V of the Older Americans Act of 1965 (4.1.5.14), except wages or salaries, which are counted as earned income.
9. Retired Senior Volunteer Program (RSVP).
10. Service Corp. of Retired Executives (SCORE).
11. University Year for Action Program (UYA).
12. Volunteers in Service to America (VISTA).
13. Wisconsin's Family Support Program (s. 46.985, WI Stats.) This program funds the unique needs of severely disabled children. They may be a vendor or a money payment.

4.1.2.3 Nutrition Benefits

Disregard benefits received from the following:

1. Emergency Food and Shelter National Board.
2. Federal Emergency Management Assistance (FEMA).
3. Food Stamp coupon allotment.
4. Home produce for household consumption.
5. National School Lunch Act.
6. Supplemental food assistance under the Child Nutrition Act of 1966.
7. Title VII Nutrition Program for the Elderly, Older Americans Act of 1965.
8. USDA Child Care Food Program.
9. USDA donated food and other emergency food.
10. WIC - the supplemental food program for women, infants, and children.

4.1.2.4 Disaster and Emergency Assistance

Disregard major disaster and emergency assistance payments made by federal, state, county, and local agencies, and other disaster assistance organizations.

4.1.2.5 IDA Payments

Disregard IDA (Individual Development Account) payments that are made in the form of matching funds to buy a home, start a business , or to complete post-secondary education.

4.1.2.6 Travel Tickets

In EBD MA cases, disregard the value of any commercial transportation ticket which the client, his/her spouse or parents (if the client is a minor) receives as a gift if it is:

1. For travel among the 50 states, District of Columbia, American Samoa, Guam, Northern Mariana Island, Puerto Rico, and the Virgin Islands.
2. Not converted to cash.

4.1.2.7 Repayments

A repayment is money the client has received from an economic support program and must give back because of a program error or violation. Since s/he is not entitled to the money, s/he must repay it. Therefore it should not be counted as income to the client.

Disregard the following repayments:

1. Money withheld from an economic assistance check due to a prior overpayment.

2. Money from a particular income source that is voluntarily or involuntarily paid to repay a prior overpayment received from that same source of income.

   If money from a particular income source is mixed with money from other types of income, disregard only an amount up to the amount of the current payment from the particular source.

Example: Richard receives $50 a month from the Veteran's Administration (VA) and $250 from Social Security. The income from the two sources is mixed together in one lump of $300. If the VA overpays Richard by $200, he can pay back to the VA only the $50 a month he receives from the VA. If he repays more, for instance, $75 a month, disregard only $50.

3. Social Security income used to repay an overpayment previously received from the Social Security Administration, whether SSA or SSI.

4.1.2.8 Reimbursements

A reimbursement is a payment which a person receives for out-of-pocket expenses. Disregard reimbursements for expenses an assistance group member has incurred or paid. Except, do not disregard reimbursements for normal household living expenses (rent, clothing, or food eaten at home).

Here are some examples of reimbursements you should disregard:

1. For job or training related expenses. The expenses may be for travel, food, uniforms, and transportation to and from the job or training site. This includes travel expenses of migrant workers.

2. For volunteers' out-of-pocket expenses incurred during their work.

3. Medical or dependent care reimbursements.

4. Reimbursement from the Indianhead Community Action Agency (Ladysmith) under its JUMP Start Program for start-up costs to set up an in-home child care business in the person's home.

5. Reimbursements received from the Social Services Block Grant Program for expenses in purchasing Social Services Block Grant services, for example, transportation, chore services, and child care services.

The reimbursement payment should not be more than the person's actual out-of-pocket expenses. If it is more, count the excess amount as unearned income.

4.1.2.9 Relocation Payments

Under s. 32.19, Wis. Stats., relocation payments are available to displaced persons. The following are examples of costs which the relocation payments are intended to cover: moving expenses, replacement housing and property transfer expenses. Disregard the amounts paid by any governmental agency or organization listed in s. 32.02, Wis. Stats. Disregard Title II, Uniform Relocation Assistance and Real Property Acquisition Policies Act payments. Its purpose is to treat persons displaced by federal and federally aided programs fairly so that they do not suffer disproportionate injuries as a result of programs designed for the public's benefit.

Disregard Experimental Housing Allowance Program (EHAP) payments. Its purpose is to study housing supply. Test areas, which include Brown County, were selected throughout the United States, and contracts were entered into prior to January 1, 1975. A sample of families was selected to receive monthly housing allowance payments.

For EBD MA clients, disregard housing assistance payments received under the following Acts:

1. United States Housing Act of 1937.
2. The National Housing Act.

3. Section 101 of the Housing and Urban Development Act of 1965.
4. Title V of the Housing Act of 1949.
5. Section 202(h) of the Housing Act of 1959.

4.1.2.10 Agent Orange Settlement Fund

Disregard payments received from the Agent Orange Settlement Fund or any other fund established in settling "In Re: Agent Orange product liability Settlement Fund litigation, M.D.L. No. 381 (E.D.N.Y.)".

Apply this disregard retroactively to January 1, 1989 and continue to disregard these payments for as long as they are identified separately.

4.1.2.11 Radiation Exposure Compensation Act

Disregard payments from any program under the Radiation Exposure Act (PL 101-426) paid to persons to compensate injury or death due to exposure to radiation from nuclear testing ($50,000) and uranium mining ($100,000). The federal Department of Justice reviews the claims and makes the payments. If the affected person is dead, payments are made to his/her surviving spouse, children, parents, or grandparents.

Apply this disregard retroactively to October 15, 1990 and continue to disregard these payments for as long as they are identified separately.

4.1.2.12 Payments to Nazi Victims

Disregard payments made under PL 103-286 to victims of Nazi persecution.

4.1.2.13 Mixed Family

When a family consists of AFDC recipients and non-recipients, include the AFDC recipients in the fiscal test group but disregard the AFDC grant in the income test.

4.1.2.14 Dottie Moore Payments

Disregard any penalty payment paid as a result of the Dottie Moore lawsuit.

These court-ordered $50-$200 penalty payments can be imposed when the Economic Support Agency (ESA) or Child Support Agency (CSA) does not correctly process child support refunds.

4.1.2.15 Zebley Payments

Disregard all SSI payments received by anyone as a result of the Zebley vs. Sullivan decision. Do not count it as income or a lump sum in the month received. Do not count it as an asset even if the family keeps the money and does not spend it.

4.1.2.16 Life Insurance

Disregard life insurance policy dividends.

4.1.2.17 Inconsequential

Disregard income which is unpredictable, irregular, and has no appreciable effect on ongoing need.

4.1.2.18 Foster Care

Disregard foster care payments.

4.1.2.19 Adoption Assistance

Disregard adoption assistance payments.

4.1.2.20 Wartime Relocation of Citizens

Disregard restitution payments under PL 100-383 to individual Japanese-Americans (or their survivors) and Aleuts who were interned or relocated during WW II.

4.1.2.21 Child Support and Maintenance

In Family MA cases (but not in EBD MA cases), disregard the first $50 of current child support paid by the absent parent(s), if it is:

Court ordered (assigned or unassigned) and paid to either:

1. The clerk of courts, or
2. Directly to or on behalf of an MA group.

If payments are made by two or more absent parents, disregard only the first $50. The disregard may not exceed $50 for each month in which child support and/or maintenance is collected or received.

4.1.2.22 Susan Walker Payments

Disregard payments received from the class action settlement of Susan Walker vs. Bayer Corporation. These payments are to hemophiliacs who contracted the HIV virus from contaminated blood products.

4.1.2.23 Spina Bifida Child

Disregard payments made under PL 104-204 to any child of a Vietnam veteran for any disability resulting from the child's spina bifida.

4.1.2.24 Kinship Care

Disregard kinship care payments.

4.1.2.25 W2 Payments

Disregard Wisconsin Works (W2) payments for Transitional Jobs and Community Service Jobs. Do not disregard payments for Trial Jobs.

4.1.2.26 Migrant Workers

Annualize migrant workers income. See 5.11.8.2.

4.1.2.27 VA Allowances

Disregard VA allowances for unusual medical expenses that are received by a veteran, their surviving spouse, or dependent. Disregard aid and attendance and housebound allowances received by veterans, spouses of disabled veterans and surviving spouses. For institutionalized and community waiver cases, disregard these allowances in eligibility and post-eligibility determinations, except for residents of the State Veterans Home at King.

For King residents the entire payment is exempt when determining eligibility, but only $90 is exempt in the post eligibility test. It applies only to those who meet the following conditions:

1. S/he is a resident at the State Veterans Home at King, and

2. S/he receives aid and attendance, unusual medical expense or housebound allowance payments in an amount greater than $90, and

3. S/he is a veteran who has no spouse or child or is a childless surviving spouse of a veteran.

Example 1: John is a veteran residing at the State Veteran's Home. His total monthly income consists of a $90 VA pension and a $55 annuity payment. The $90 VA pension is totally disregarded in eligibility and post eligibility determinations. The personal needs allowance for institutionalized clients is deducted from the $55 annuity payment. John's remaining budgetable income in the MA post-eligibility determination is $10, and that $10 will be applied to his patient liability.

Example 2: Scott is a veteran residing at the State Veteran's Home. His total monthly income consists of a $590 VA pension ($200 of which is for unusual medical expenses) and a $50 annuity payment. The portion of the VA pension for unusual medical expenses is totally disregarded in the MA eligibility test. The $50 annuity payment and remaining $390 of the VA pension is non-exempt income. For the post-eligibility test, only $90 of the VA pension is disregarded. The patient liability calculation includes the personal needs allowance, so Scott will have to contribute $505 to his patient liability.

Eligibility Calculation
$590 VA Pension
<u>+ 50 Annuity</u>
$640
<u>-200 (exempt income)</u>
$440 countable income

Liability Calculation
$590 VA Pension
<u>+ 50 Annuity</u>

$640 -   90 (exempt income) <u>-   45 (personal needs)</u> $505 patient liability

4.1.2.28 Crime Victim Restitution Program

Disregard any payments received from a state established fund to aid victims of a crime.

4.1.2.29 EBD General Income Disregard

Disregard $20 from the EBD fiscal test group's net income.

This page last updated in Release Number : 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

4.1.3 Income Deductions

4.1.3.1 Maintaining Home or Apartment

If an institutionalized person has a home or apartment, deduct an amount from his/her income to allow for maintaining the home or apartment.

Make the deduction only when the following conditions are met:

1. A physician certifies (verbally or in writing) that the person is likely to return to the home or apartment within six months, and

2. The person's spouse is not living in the home or apartment.

The amount is in addition to the personal needs allowance (8.1.5). It may not exceed the SSI payment level plus the E Supplement for one person (8.1.5). It should be enough for mortgage, rent, property taxes (including special assessments), home or renters insurance, utilities (heat, water, sewer, electricity, and other incidental costs.

Deduct it for no more than six months. If the person is re-admitted to the institution, grant a six month continuance. A physician must again certify that s/he is likely to return to the home or apartment within six months.

The home maintenance allowance can be granted at any time as long as the person is institutionalized. It is not limited to the first six months of institutionalization.

Example: Bob was institutionalized in June 2003 as a private pay patient. In June 2004, he qualifies for Medicaid and is potentially eligible for the home maintenance

allowance. Bob's doctor says he is expected to return home by November 2004. He is eligible for the deduction from his income when determining the amount of his income available for his cost of care starting in June 2004.

4.1.3.2 Special Exempt Income

Special exempt income includes:

1. Income used for supporting others (4.1.3.2.1).
2. Court-ordered attorney fees (4.1.3.2.3).
3. Court-ordered guardian and guardian ad litem fees (4.1.3.2.3).
4. Expenses associated with establishing and maintaining a guardianship. (4.1.3.2.3)
5. Expenses associated with a Self-Support Plan (4.1.3.2.2).
6. Impairment Related Work Expenses (IRWE) (4.1.3.4).
7. Maintaining a home or apartment (4.1.3.1)

For specific exemptions see 4.1.2

4.1.3.2.1 Support Payments

Support payments are payments which an MA client makes to another person outside of the FTG for the purpose of supporting and maintaining that person. Support payments are either court-ordered or non-court-ordered.

Include the support payment amount as part of an institutionalized person's monthly need (5.8.6) and cost of care (5.8.7).

A person in the fiscal group who has legal responsibility for a person in a nursing home may be paying that person's patient liability. If so, deduct this amount from the group's income.

Court-Ordered. Include all court-ordered support payments, including child support, that the client is obligated to pay based on past payment history.

Example: In 2000, George was ordered to pay $500 per month in child support for his son Rosco. In February 2002, George had a car accident and has since been placed in a nursing home. George has not made a child support payment since November 2002.

George submitted an application in November 2003. Since George has not make a child support payment in over a year do not include child support payments in his eligibility determination. .

Non-court-Ordered. Include non-court-ordered support payments only if they are paid to the following:

1. Institutionalized spouse. The maximum amount that can be included is

the AFDC Cat Needy income limit for a group size of one (8.1.4) minus the spouse's net income.

2. Minor child who is living with a non-legally responsible relative (NLRR). The maximum amount that can be included is the AFDC cat needy income limit for a group size of one plus the child's medical expenses minus the child's net income.

Do not include non-court-ordered payments if they are to:

1. A spouse or minor child who receives SSI, or
2. A spouse who is eligible for SSI but refuses to apply for it.

4.1.3.2.2 Self-Support Plan

A client whose eligibility is based on blindness or disability may deduct income that is received under an approved self-support plan. This allows a handicapped person to receive income and accumulate resources for training or purchasing equipment necessary for self support. Where all requirements are met, income from any source, earned or unearned, is deducted and allowed to accumulate to the extent specified in the plan.

To qualify for this deduction, the client must perform in accordance with the plan. The plan must:

1. Be specific, current, and in writing.
2. Be approved by the county or tribal agency.
3. Specify the amount to be set aside, and the expected cost and time required to accomplish the objective.
4. Provide for identification and segregation of goods and money accumulated and conserved.

4.1.3.2.3 Fees to Guardians or Attorneys

Count as available income any payments an institutionalized person makes to:

1. A legal guardian or attorney which are not court-ordered payments. Do not include such payments in the person's monthly need, and do not deduct them from his/her monthly income.

2. A third party to reimburse a prepayment the third party made of a guardianship fee. Count the payment even if the third party obtained a court order to recoup the pre-payment.

   Exception: Deduct this third party prepayment if:

   a. The third party was the county acting as guardian ad litem. A guardian ad litem is someone appointed by the court to represent the best interests of a juvenile or disabled person during a particular court proceeding.

b. The prepayment was to an attorney who was not a county employee at the time the services were delivered.

c. A court ordered the institutionalized person to reimburse the county's prepayment.

Do not count the following as available income:

1. Court-ordered guardian and/or attorney fees paid directly out of the person's monthly income.

2. Expenses paid by the person for establishing and maintaining a court-ordered guardianship or protective placement for him/herself.

4.1.3.3 Medical/Remedial Expenses (MRE)

Medical and Remedial Expenses (MRE) are used in waiver and Family Care Non-MA eligibility determinations, as well as in cost share and Medicaid Purchase Plan (MAPP) premium calculations.

Medical expenses are anticipated incurred expenses for services or goods that have been prescribed or provided by a professional medical practitioner (licensed in Wisconsin or another state). The expense is for diagnosis, cure, treatment, or prevention of disease or for treatment affecting any part of the body. These are expenses that are the responsibility of the client, and cannot be reimbursable by any other source, such as MA, private insurance, or employer.

The following are examples of medical expenses:

1. Deductibles and co-payments for MA, Medicare, and private health insurances.

2. Health insurance premiums.

3. Bills for medical services which are not covered by the Wisconsin MA program.

4. For purposes of meeting a MA deductible, medical services received before the person became eligible for MA. (Past medical bills cannot be used for MAPP premium calculations.)

Remedial expenses are costs incurred for services or goods that are provided for the purpose of relieving, remedying, or reducing a medical or health condition.

These are expense that are the responsibility of the client and cannot be reimbursable by any other source, such as MA, private insurance, or employer.

Some examples of remedial expenses are:

1. Case management.
2. Day care.
3. Housing modifications for accessibility.
4. Respite care.
5. Supportive home care.
6. Transportation.
7. Services recognized under s.46.27, Wis. Stats.,
8. Community Options Program, that are included in the person's service plan.

Remedial expenses do not include housing or room and board services.

4.1.3.4 Impairment Related Work Expenses (IRWE)

Impairment Related Work Expenses (IRWE) are expenses used to determine eligibility for EBD MA, MAPP eligibility and premium calculations. IRWEs are anticipated incurred expenses by the client related to the client's impairment and employment. The expense cannot be one that a similar worker without a disability would have, such as uniforms. The expense cannot be reimbursable by a legally obligated third party such as MA, private insurance, or the client's employer. If an anticipated IRWE is later paid by an unanticipated source it is still allowable for past months in which it was budgeted, but not for future months.

Example: On March 25, Cecil was told by Harvey's Auto Repair Shop that his wheelchair accessible van required repairs to fix the specialized door ramp. Cecil received an estimate of $2,000 for the repairs. The $2,000 estimate was determined to be a standard charge for this type of repair in the community.

On March 26, Cecil applied for MA in Milwaukee County. At this time the anticipated expense of the van repair was deducted from Cecil's income.

Cecil delayed making the repairs until May 27, when the van's wheelchair accessible door completely quit working. At that time Cecil's friend Robin paid Harvey's Auto Repair Shop for the repairs to Cecil's van door. Cecil reported the repairs and the source of the money for the repairs to his ES worker.

Cecil's ES worker should not deduct the anticipated cost of the van repairs for any subsequent eligibility and premium determinations.

Deduct any EBD person's expenses which:

1. Do not exceed his/her gross monthly earned income (plus room and board income, if any).

2. Are reasonably related to his/her earned in-come. Expenses which are reasonably related to earned income include those incurred in performing on the job and improving the person's ability to do the job.

Bills from months prior to months for which eligibility is being determined are not an allowable IRWE. This is true even if it is currently being paid.

Determine a standard charge for the item or service based on what is representative for the client's community. If you count an expense as an IRWE, do not also use the expense as a Medical/Remedial Expense (MRE).

Some examples of IRWEs are: Modified audio/visual equipment, typing aides specialized keyboards, prostheses, reading aids, vehicle modification (plus installation, maintenance, and associated repair costs), and wheelchairs.

Do not allow the expense of getting to and from work as an IRWE, unless the expense is related to the client's disability.

Exception: Always count the expense of getting to and from work as an IRWE for blind individuals.

4.1.3.5 $90 Earned Income Disregard

When testing a MA client for Family MA, disregard $90 for each individual in the household that is employed.

4.1.3.6 $65 and ½ Earned Income Disregard

The $65 and ½ earned income disregard is an EBD fiscal test group disregard.

To calculate the $65 and ½ earned income disregard, subtract $65 from the client's monthly earned income. Divide the result by two, and add $65. This is the earned income disregard.

Example: Michelle has monthly income of $1,240. Her $65 and ½ earned income disregard is

$1,240.00
<u>–   65.00</u>
$1,175.00

$1,175.00/2 = $587.50 Countable Income

$ 587.50
<u>+   65.00</u>
$ 652.50 Earned Income Disregard

Michelle's earned income disregard amount is $652.50.

This page last updated in Release Number : 05-01
Release Date: 01/11/05
Effective Date: 01/11/05

4.1.4 Unearned Income

Unearned income is income that the client receives from sources other than employment. Unless it is disregarded income (4.1.2) or an income deduction (4.1.3), count it in the person's income total.

4.1.4.1 Income from Trusts

A trust is any arrangement in which a person (the "grantor") transfers property to another person with the intention that that person (the "trustee") hold, manage, or administer the property for the benefit of the grantor or of someone designated by the grantor (the "beneficiary").

The term "trust" includes any legal instrument or device or arrangement which, even though not called a trust under state law, has the same attributes as a trust. That is, the grantor transfers property to the trustee and the grantor's intention is that the trustee hold, manage, or administer the property for the benefit of the grantor or of the beneficiary.

The grantor can be:

1. The MA client.

2. The spouse of the MA client.

3. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the client or the client's spouse. This includes a power of attorney or guardian.

4. A person, including a court or an administrative body, acting at the

direction or upon the request of the client or the client’s spouse. This includes relatives, friends, volunteers or authorized representatives.

All payments (including interest, dividends, and rent) from a trust to the beneficiary are unearned income to the beneficiary. This includes payments **made** directly to vendors for services provided to the beneficiary. Examples include payments from trusts to a landlord for rent, payment to a utility for electricity, or payments to the telephone company for the beneficiaries phone service. See (4.1.4.9) for instructions on counting interest.

Do not count withdrawals from the trust principal as income when the withdrawals are in addition to or are an exception to payments under the terms of the trust agreement. These withdrawals are a conversion of an asset from one form to another.

If the beneficiary does not receive payments (including interest, dividends, and rent) from the trust, but they are added back to the trust principal:

1. Do not count them as income to the beneficiary if the beneficiary is elderly, blind or disabled.

2. Count them as income to the beneficiary if the beneficiary is Family MA. Except: Do not count the payments if they are irrevocable interest payments from an irrevocable trust. An “irrevocable trust” is a trust that cannot, in any way, be revoked by the grantor.

Note: If the grantor is an institutionalized person , or acting on behalf of an institutionalized person, payments from any trust, both revocable and irrevocable, that are not to or for the benefit of the institutionalized person are divestment (4.7.13).

4.1.4.2 Sick Benefits

Sick benefits received from insurance such as income continuation.

4.1.4.3 Unemployment Compensation (UC)

Count UC that is intercepted to collect child support as if the UC beneficiary actually received the intercepted dollars. For Family Care Non-MA, count UC as earned income.

4.1.4.4 Retirement Benefits

Retirement benefits include work-related plans for providing income when employment ends (e.g. pension disability or retirement plans administered by an employer or union)

Other examples of retirement funds include accounts owned by the individual, such as Individual Retirement Accounts (IRA) and plans for self-employed individuals, sometimes referred to as KEOGH plans.

Periodic payments made from a work-related retirement benefit plan should be counted as income in the month of receipt. Payments from an ineligible spouse's work related pension account are also counted as income to the ineligible spouse

Any periodic payments from individually owned accounts (e.g., IRA) should not be counted as income in the month of receipt. They are considered the same as withdrawals from an applicant's savings account. Only interest earned on the funds in a retirement fund should be counted as income according to (4.1.4.9).

Consider IRAs, Keoghs, or other retirement funds that are completely cashed in as a conversion from one asset form to another.

Example: Mike withdraws $2,000 he has in an IRA, and deposits it into a savings account. Continue to treat the $2,000 as a countable asset. This is just a conversion from one form of an asset to another. Treat any interest that Mark receives as income in the month received.

4.1.4.5 General Relief and Charity

Count unrestricted General Relief and charitable payments as follows:

1. Subtract the process month's Family Allowance from the Assistance Standard for this size fiscal group.
2. Multiply the difference by 12 to get the maximum payment you can disregard.
3. Ignore any payment that is less than the maximum.
4. Subtract from the maximum the amount of any payment that is greater than the maximum.
5. Count the remainder as unearned income.

4.1.4.6 Gifts

A gift is something a person receives which is not repayment for goods or services the person provided and is not given because of a legal obligation on the giver's part. To be a gift, something must be given irrevocably (that is, the donor relinquishes all control).

Treat non-cash gifts as an asset, as you would an asset of a similar type. A cash gift is unearned **income** in the month of receipt. It is an **asset** in the months after the month of receipt

Disregard cash gifts (such as for birthdays, graduation, and Christmas) that total $30 or less, for each assistance group member, for each calendar quarter.

4.1.4.7 Land Contract

Count any portion of monthly payments received that are considered interest from a land contract as unearned income. Do not count the principal as income, because it is the conversion of one asset form to another. Deduct from the gross amount any expenses the person is required to pay by the terms of the contract.

If the income is received less often than monthly, prorate the income to a monthly amount. Do not begin budgeting this monthly amount until the person first receives a payment after becoming eligible.

Example: Bob receives land contract payments from Farmer Brown twice a year, one $500 payment in March and another $500 payment in September.

If Bob is applying in February prorate the land contract payments Bob receives after he becomes eligible. In March when Bob receives a $500 land contract payment, divide the total income ($500) by the frequency of the payments (six months) to get the budgeted income amount of $83.33 per month ($500/6 months = $83.33). Begin budgeting this amount in March.

4.1.4.8 Loans

If an AG member makes a loan (except a land contract), treat the repayments as follows:

1. Count the interest as unearned income in the month received. In the months following the month the interest payment was received, count the interest payment as an asset.

2. Count any repayments toward the principal of the loan, whether it is a full payment, a partial payment, or an installment payment, as an asset.

If an AG member receives a loan and it is available for current living expenses, count it as an asset. Do this even if there is a repayment agreement. If it is not available for current living expenses, disregard it.

4.1.4.9 Interest Income

Count interest income (except from life insurance) as unearned income when it:

1. Is received regularly and frequently, and
2. Is more than $20 a month.

When income is received less often than monthly, prorate (4.1.6.1.2) it to a monthly amount. Wait until the person first receives it after becoming eligible, then begin the proration with the month in which the payment is received.

If the prorated amount is $20 or less, disregard it as inconsequential income. If more than $20, budget it as unearned income.

Example 1: In a Family MA application, made June 16, 1991, a group member receives interest payments of $54 every three months. The next interest payment date is July 30, 1991. Do not count any of this interest income during June. Prorate the payment over July, August, and September. The interest is: $54/3 = $18. Since $18 is less than $20, do not count the interest.

When interest is paid regularly, but the amount fluctuates, average the payments to get a monthly amount.

When you discover that interest has accumulated in an account, count all of the accumulated interest as unearned income. Do not count these interest dollars as an asset.

Example 2: In May, $12 is posted to an account as monthly interest on principal of $800. May income is $12 and the May asset is $800. In June, $12.50 is posted as interest on a balance of $812. June income is $12.50 and the June asset is $812.

If interest is not paid regularly (neither you nor the client can reasonably predict when it will be available), count the interest as unearned income in the month in which it is received.

4.1.4.10 Social Security Benefits

Count Social Security Benefits as income in the month received.

4.1.4.11 Property Settlement

See Assets, 4.5.7.10.

4.1.4.12 Lump Sum Payments

See Assets, 4.5.7.11.

4.1.4.13 Money for School

See Money for School, 4.4.

4.1.4.14 Child Support

Count child support income as unearned income.

4.1.4.15 Profit Sharing

Count profit sharing income as unearned income.

4.1.4.16 Income Received by Members of a Religious Order

Count any compensation that a member of a religious order receives, not related to gainful employment, as unearned income even if the compensation is turned over to the order.

Count the compensation as earned income if it meets the criteria in 4.1.5.13

This page last updated in Release Number : 05-01
Release Date: 01/11/05
Effective Date: 01/11/05

4.1.5 Earned Income

Earned income is income from gainful employment.

4.1.5.1 Income In Kind

Count in-kind benefits as earned income if they are:

1. Regular, and
2. Predictable, and
3. Received in return for a service or product.

Do not count:

1. Meals and lodging for armed services members.
2. In-kind services that do not meet all three of the above criteria.

To determine the value of in-kind benefits, use the prevailing wage (but not less than the minimum wage) in the community for the type of work the person does to earn the benefits.

4.1.5.2 Contractual Income

This provision applies primarily to teachers and other school employees.

When an employed MA group member is paid under a contract rather than on an hourly or piecework basis, determine the period of the contract and then prorate the income from the contract over that period. For example, if the contract is for 18 months, prorate the contract's income over 18 months no matter the number of installments made in paying the income. Do this even if:

1. There are predetermined vacation periods, or
2. S/he will only be paid during work periods, or
3. S/he will be paid only at the end of the work period, season, semester or school year.

4.1.5.3 Rental Income

When a MA group member reports rental income to the Internal Revenue Service (IRS) as self-employment income, see 4.2.3 and 4.2.4.

If s/he does not report it as self-employment income, add "net rent" to any other unearned income on the appropriate worksheet. Determine "net rent" as follows:

1. When the owner is not an occupant, "net rent" is the rent payment received minus the interest portion of the mortgage payment, and other verifiable operational costs. Operational costs include ordinary and necessary expenses such as insurance, taxes, advertising for tenants, and repairs. Repairs include such expenses as repainting, fixing gutters or floors, plastering, and replacing broken windows.

   Capital expenditures are not deductible from gross rent. A capital expenditure is an expense for an addition or increase in the value of the property. It would include improvements such as finishing a basement, adding a room, putting up a fence, putting in new plumbing, wiring or cabinets, paving a driveway.

   If an institutionalized person has excess operational costs above the monthly rental income, carry the excess costs over into later months until they are offset completely by rental income. But do the carryover only until the end of the year in which the expenses were incurred.

   When a life estate (4.5.8.1.5) holder moves off the property and the property is rented, count the net rental income the holder is entitled to receive. Net rental income is the gross rental income minus taxes, insurance, and other operational costs. The operational costs are the same as the costs the holder was liable for when living on the property

2. When s/he receives income from a duplex, triplex, etc. and lives in one of the units, determine "net rent" as follows:

   a. Add the interest portion of the mortgage payment and other verifiable operational costs common to the entire operation.

b. Multiply the number of rental units by the total in "a."

c. Divide the result in "b." by the total number of units. This is the proportionate share.

d. Add the proportionate share "c." to any operational costs paid by the client that are unique to any rental unit. The result is the total client expense.

e. Subtract the total client expense "d." from the total rent payments to get "net rent."

4.1.5.4 Jury Duty Payments

Count any portion of a jury payment that is over and above expenses as earned income for the month in which it is received.

4.1.5.5 Wage Advances

Count advances on wages as earned income in the month received.

4.1.5.6 Worker's Compensation

Worker's compensation is compensation for lost wages which would have been earned, except for an injury suffered during the course of employment. Count worker's compensation as earned income in Family Care Non-MA and Family MA cases. For EBD cases, it is unearned income.

4.1.5.7 Governor's Central City Initiative

Count hourly income from the Governor's Central City Initiative as earned income. This program is only in Milwaukee County.

4.1.5.8 Income and EITC Tax Refunds

See Assets, 4.5.7.7 and 4.5.7.8.

4.1.5.9 Student Income

Disregard a client's income if s/he:

1. Meets the definition of a dependent 18-year-old (3.5.1.3), **or**
2. Is under age 19, and a full-time student, **or**
3. Is under age 19, and part-time student working less than 30 hours per week.

Count the earned income of anyone under age 19 who does not meet any of the criteria listed above.

4.1.5.10 AmeriCorps

Count the living allowance or stipend as earned income. Disregard any child care allowance to the extent is was used to meet child care expenses to participate in AmeriCorps. Disregard any basic health insurance policy, child care services, auxiliary aid and services to people with disabilities and the national service educational award of $4,725 for each year of completed service.

4.1.5.11 Census 2000

Disregard all wages paid by the Census Bureau for temporary employment related to Census 2000. Apply this disregard from February 1, 2000 through December 31, 2000.

4.1.5.12 Severance Pay

Count severance pay as earned income in the month of receipt. Count severance pay that has been deferred at the employee's request or through a mutual agreement with his/her employer as earned income when s/he would have received the amount had it not been deferred.

4.1.5.13 Income Received by Members of a Religious Order

Count any compensation that a member of a religious order receives as earned income if the compensation is for gainful employment, even if the compensation is turned back over to the order.

Count the compensation as unearned income if it is not earned through gainful employment.

4.1.5.14 Title V – Older Americans Act of 1965

Count only wages and salaries paid to individuals as a result of their participation in a program funded under Title V of the Older Americans Act of 1965 as earned income.

These programs include, but are not limited to:

1. Green Thumb.
2. Experience Works.
3. The National Urban League.
4. National Senior Citizens Education and Research Center (Senior Aides).
5. National Indian Council on Aging.
6. U.S.D.A Forest Service.
7. Wisconsin Senior Employment Program (WISE).
8. Community service employment programs, such as the Older Americans Community Service Program.

Identify programs funded under the Title V of the Older Americans Act using documents provided by the client, contacts with the provider, or a local council on aging.

Do not count reimbursements (4.1.2.8).

4.1.5.15 Room and Board Income

Calculate net amount by deducting one of the following from the gross amount received from each roomer/boarder: $15 roomer only, $111 Boarder only, $126 roomer and boarder.

This page last updated in Release Number : 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

4.1.6 Prospective Income

Use the self-declared gross income amount when a client is **only** applying for MA unless that information is deemed questionable. Convert only if the client is applying for other benefits. Do not consider the monthly declared amount “questionable” on the basis of lack of detail regarding hours of work and pay rate per hour.

4.1.6.1 Budgeting Techniques

If the client applies for MA, use actual income in determining eligibility. If the client applies for any other program of assistance in addition to MA, determine eligibility using the appropriate income calculation from the chart below.

Pay Cycle	**Income Calculation**
Weekly	hourly rate x hrs/week x 4.3 = prospective monthly income
Bi-weekly	hourly rate x hrs/pay period x 2.15 = prospective monthly income
Semi Monthly	hourly rate x hrs/pay period x 2 = prospective monthly income
Monthly	hourly rate x hrs/month = prospective monthly income

If the client applies only for MA, do not use the conversion factors in determining income because the use of the conversion factors may negatively impact the client’s countable income.

Example 1: Mrs. M, who is disabled, worked 20 hours per week at the Ho Chunk casino until recently when she was laid off. She now receives $150 weekly for unemployment. When she applies for MA, the $20 disregard is applied and her countable income of $580 is under the limit of $591.67.

$150/unemployment check X 4 unemployment checks

= $600/month.

$600 - $20 disregard = $580

Example 2: If Mrs. M. also applies for food stamps her income is determined by using the conversion factor of 4.3, rather than the actual amount received in the month. This changes the determination of her monthly income.

$150/unemployment check X 4.3 unemployment checks/month = $645
When she applies for MA the $20 disregard is applied:
$645 - $20 = $625

Because Mrs. M. has applied for food stamps and MA, the use of a conversion factor has adversely affected her MA application by increasing her countable income. Her income is now determined to be $625 per month, and exceeds the monthly income limit of $591.67.

$625 - $591.67 = $33.33

As a result she now has a $199.98 deductible, and would not qualify for MA until she met her deductible.

$33.33 X 6 months = $199.98

Since this determination has an adverse affect on the client's MA eligibility. MA eligibility should be determined manually with actual income.

4.1.6.1.1 Fluctuating Income

If the amount or frequency of regularly received income is known, average the income over the period between payments. If neither the amount nor the frequency is predictable, do not average; count income only for the month in which it is received.

4.1.6.1.2 Prorating Income

Income received on a yearly basis or less often than monthly, that is predictable in both amount and frequency, must be converted to a monthly amount or prorated.

Prorate means "to distribute proportionately."

Example 1: Sally receives a $1,500 Tribal Distribution Payment quarterly. This payment should be prorated for the months between payments. $1,500 is distributed over three months by dividing the amount of money by the number of months between payments. The prorated amount is $1,500/3= $500 a month.

Prorating is applied to a client's income when the income is received less often than monthly. By prorating, income is distributed evenly over the number of months between payments

Farm and self-employment income (4.2) is either averaged or prorated.

When an assistance group applies, do not count the prorated income until it is received.

Example 2: Joe receives semiannual land contract installments of $900. This equals a monthly income of $150 ($900 prorated over six months). He becomes eligible in May. He receives payments in January and July each year. Do not budget any prorated income until July, the first month of receipt after Joe becomes eligible.

If the group becomes ineligible and reapplies before they receive the next installment, use the same prorated amount as before.

This page last updated in Release Number : 05-01
Release Date: 01/11/05
Effective Date: 01/11/05

4.1.7 FPL Income Limits

See 8.1.6

This page last updated in Release Number: 04-01
Release Date: 04/01/03
Effective Date: 04/01/03

4.2 SELF EMPLOYMENT INCOME

4.2.1 Definitions

4.2.1.1 Income

Self-employment income means income directly from one's own business rather than as an employee with a specified salary or wages from an employer.

4.2.1.2 Business

Business means an occupation, work, or trade in which a person is engaged as a means of livelihood.

4.2.1.3 Operating

A business is operating when it is ready to function in its specific purpose. The period of operation begins when the business first opens and generally continues uninterrupted up to the present. A business is operating even if there are no sales and no work is being performed. Thus a seasonal business operates in the off season unless there's been a significant change in circumstances (4.2.5.3).

A business isn't operating when it can't function in its specific purpose. For instance, if a mechanic can't work for 4 months because of an illness or injury, he may claim his business wasn't in operation for those months.

4.2.1.4 IM Income

IM income means self-employment income that is counted in determining economic assistance eligibility and benefits.

4.2.1.5 Real Property

Real property means land and most things attached to the land, such as buildings and vegetation.

4.2.1.6 Nonreal Property

Nonreal property means all property other than real property.

This page last updated in Release Number : 00-01
Release Date:01/01/00
Effective Date: 01/01/00

4.2.2 Ways to Identify

Identify a farm or other business according to the following criteria.

4.2.2.1 By Organization

A farm or other business is organized in 1 of 3 ways:

1. A sole proprietorship, which is an unincorporated business owned by one person.

2. A partnership, which exists when 2 or more persons associate to conduct business. Each person contributes money, property, labor, or skills, and expects to share in the profits and losses. Partnerships are unincorporated.

3. A corporation is a legal entity authorized by a state to operate under the rules of the entity's charter. There may be one or more owners. A corporation differs from the other forms because a corporation:

    a. Is taxed as a separate entity rather than the owners being taxed as individuals, and

    b. Provides only limited liability. Each owners' loss is limited to their investment in the corporation while the owners of unincorporated business is also personally liable.

4.2.2.2 By IRS Tax Forms

A self-employed person who earns more than $400 net income must file an end-of-year return. A person who will owe more than $400 in taxes at the end of the year must file quarterly estimates.

IRS tax forms for reporting self-employment income are listed below.

1. Form 1065 - Partnership
2. Form 1120 - Corporation
3. Form 1120S - S Corporation
4. Form 4562 - Depreciation & Amortization
5. Form 1040 - Sole Proprietorship

    a. Schedule C (Form 1040) - Business (non-farm)
    b. Schedule E (Form 1040) - Rental and Royalty
    c. Schedule F (Form 1040) - Farm Income
    d. Schedule SE (Form 1040) - Social Security Self-Employment

4.2.2.3 Employee Status

A person is an employee if s/he is under the direct "wield and control" of an employer. The employer has the right to control the method and result of the employee's service. A self-employed person earns income directly from his/her own business, and:

1. Does not have federal income tax and FICA payments withheld from a paycheck.
2. Does not complete a W-4 for an employer.
3. Is not covered by employer liability insurance or worker's compensation.
4. Is responsible for his/her own work schedule.

Examples of self-employment are:

1. Businesses that receive income regularly (for example, daily, weekly or monthly):

   a. Merchant.
   b. Small business.
   c. Commercial boarding house owner or operator.
   d. Owner of rental property.

2. Service businesses that receive income frequently, and possibly, sporadically:

   a. Craft persons.
   b. Repair persons.
   c. Franchise holders.
   d. Subcontractors.
   e. Sellers of blood and plasma.
   f. Commission sales persons (such as door-to-door delivery).

3. Businesses that receive income seasonally:

   a. Summer or tourist oriented business.
   b. Seasonal farmers (custom machine operators).
   c. Migrant farm worker crew leaders.
   d. Fishers, trappers, or hunters.
   e. Roofers.

4. Farming, including income from cultivating the soil, or raising or harvesting any agricultural commodities. It may be earned from full-time, part-time or hobby farming.

4.2.3 Assets

4.2.3.1 Business Assets

Business assets are generally income producing property. Exclude assets directly related and essential to producing goods or services.

4.2.3.1.1 EBD

In EBD cases, all real and nonreal business property is exempt if the business is currently operating (4.2.1.3) for the self-support of the EBD individual. There is no profitability test.

Ask the EBD person to furnish the documents (4.2.2.2) needed to:

1. Describe the business, its properties, and its assets.
2. Show the number of years it has been operating.
3. Identify any co-owners.
4. Show the estimated gross and net earnings for the current tax year.

If the property is not currently operating, exempt it if there is reasonable expectation it will resume operating within the next 12 months. Base your reasonable expectation on the following information:

1. Date of last use.
2. Reason property is not in current use.
3. Estimated date the person expects to resume use.

If s/he decides not to resume, the property becomes a countable asset in the month after the decision not to resume.

Extend the 12 months only when a disabling condition prevents the person from resuming business use of the property.

4.2.3.2 Bank Accounts

With corporations you can easily distinguish between personal and business checking and savings accounts. A corporation is a separate legal entity and the accounts it owns must be in the corporation's name. Accounts in the name of the owners are personal accounts.

For partnerships and sole-proprietorships, a cash account is a business account if the person claims that it is a business account. Disregard a business account, if the profitability test is passed, even if a partner or sole-proprietor makes withdrawals from the account for personal use. You don't need a profitability test for EBD cases.

This page last updated in Release Number : 02-01
Release Date : 10-01-01
Effective Date :10-01-01

4.2.4 Income

All self-employment income is earned income, except royalty income and some rental income (4.2.4.1).

Self-employment income is income that is reported to IRS as farm or other self-employment income or as rental or royalty income. When income isn't reported to IRS, you must judge whether or not it is self-employment income.

4.2.4.1 Income Sources

Self-employment income sources are:

1. **Business.** Income from operating a business.

2. **Capital Gains.** Income from selling securities and other property.

3. **Rental.** Rental income is rent received from properties owned or controlled. Rental income is either earned or unearned. It is earned only if the owner actively manages the property on an average of 20 or more hours per week. It is unearned when the owner reports it to the IRS as other than self-employment income.

   Use "net" rental income in the eligibility determination. "Net" rental income means gross rental receipts minus business expenses.

   When the owner isn't an occupant, net rental income is the rent payment received minus the interest portion of the mortgage payment and other verified operational costs.

   When a life estate (4.5.8.1.5) holder moves off the property and the property is rented, net rental income is the rent payment received minus taxes, insurance, and operational costs. The operational costs are the same as the costs the holder was liable for when living on the property.

   When the owner lives in one of the units of a multiple unit dwelling, compute net rental income as follows:

   a. Add the interest portion of the mortgage payment and other operational costs common to the entire operation.

b. Multiply the number of rental units by the total in step 1.

c. Divide the result in step 2 by the total number of units, to get the proportionate share.

d. Add the proportionate share to any operational costs paid that are unique to any rental unit. This equals total expenses.

e. Subtract total expenses from the total rent payments to get net rent.

4. Royalties. Royalty income is unearned income received for granting the use of property owned or controlled. Examples are patents, copyrighted materials or a natural resource. The right to income is often expressed as a percentage of receipts from using the property or as an amount per unit produced.

This page last updated in Release Number: 02-01
Release Date: 10-01-01
Effective Date:10-01-01

4.2.5 Calculating IM Income

Calculate IM income (4.2.1.4) by either:

1. Using IRS tax forms completed for the previous year, **or**
2. Anticipating earnings (4.2.5.3).

4.2.5.1 IRS Tax Forms

Don't fill out any IRS tax forms (or the Self-Employment Income Report Form-DES 2131) yourself. This is the responsibility of the client.

Consult IRS tax forms only if:

1. The business was in operation at least one full month during the previous tax year, and

2. The business has been in operation six or more months at the time of the application, and

3. The person doesn't claim a change in circumstances since the previous year.

If all three conditions aren't met, use anticipated earnings (4.2.5.3).

4.2.5.2 Worksheets

If you decide to use IRS tax forms, use them together with the self-employment income worksheets (HCF 16034 , HCF 16035 , HCF 16036 and HCF 16037).

The worksheets identify net income and depreciation by line on the IRS tax forms.

For each operation, select the worksheet you need and, using the provided tax forms and/or schedule, complete the worksheet. These are:

1. **Sole Proprietor** - Farm and Other Business

    a. IRS Schedule C (Form 1040) – Non-farm Business Income
    b. IRS Schedule E (Form 1040) - Rental and Royalty Income
    c. IRS Schedule F (Form 1040) - Farm Income
    d. IRS Form 4797 - Capital & Ordinary Gains

2. **Partnership**

    a. IRS Form 1065 - Partnership Income
    b. IRS Schedule K-1 (Form 1065) - Partner's Share of Income

3. **Corporation**

    IRS Form 1120 - Corporation Income

4. **Subchapter S Corporation**

    a. IRS Form - 1120S - Small Business Corporation Income
    b. IRS Schedule K-1 (Form 1120S - Shareholder's Share of Income

Next, divide IM income by the number of months that the business was in operation during the previous tax year.

The result is monthly IM income. Add this to the fiscal test group's other earned and unearned income. If monthly IM income is a loss, add zero to the non self-employment income.

When a household has more than one self-employment operation, the losses of one may be used to offset the profits of another. Apply this offset only to those self-employment operations that produced earned income. Don't apply a loss from unearned income to a gain in earned income. Losses from self-employment can't be used to offset other earned or unearned income.

If you use more than one worksheet because there is more than one operation, combine the results of each worksheet into one monthly IM income amount before adding that total to any other income. Remember that while a salary or wage paid to a FTG member is an allowable business expense, you must count it as earned income to the payee.

Continue to process the group through the balance of the handbook, including some additional work-related expenses that IRS doesn't allow as business expenses (4.1.3.5),(4.1.3.6).

4.2.5.2.1 Depreciation

EBD persons must deduct depreciation from their self-employment income. The amount of the depreciation deduction is the same as the amount they claim on their tax forms.

For Family Medicaid, do not allow the following deductions when calculating gross self-employment income:

1. Depreciation (also called depletion or amortization).
2. Transportation to/from work.
3. Purchase of capital equipment.
4. Payment on the principal of loans for capital assets or durable goods.

If using an IRS form (4.2.2.2) provided by the client, add depreciation back into the net income indicated on the form. The reason is the IRS allows depreciation as an income deduction but Family MA does not.

4.2.5.3 Anticipating Earnings

If past circumstances don't represent present circumstances, calculate self-employment income on anticipated earnings. A change in circumstances is any change that can be expected to affect income over time. It is the person's responsibility to report changes.

The date of an income change is the date you agree that a change occurred. You must also judge whether the person's report was timely to decide if the case was over or underpaid. Changes are then effective according to the normal retrospective budgeting cycle. Don't recover payments made before the agreed on date.

Other instances when you would use anticipated earnings:

1. The business wasn't operating at least one full month during the previous tax year.

2. The business wasn't operating six or more months at the time of the interview.

Examples of changed circumstances are:

The owner sold or simply closed down the business.
The owner sold a part of his business (e.g., one of two retail stores).
The owner is ill or injured and will be unable to operate the business for a period of time.
A plumber gets the contract on a new apartment complex. The job will take nine months and his/her income will increase.
A farmer suffers unusual crop loss due to the weather or other circumstances.
There's a substantial cost increase for a particular material such that there will be less profit per unit sold.
Sales, for an unknown reason, are consistently below previous levels. The relevant period may vary depending on the type of business (consider normal sales fluctuations).

To anticipate earnings:

1. Average IM income over the past months beginning when circumstances changed if six or more months have passed since the change.

2. Calculate a cumulative monthly average when the change was less than six months ago, and when a new business has been operating less than six months.

3. Use the six months' average until the person reports a completed IRS tax form or reports a change in circumstances at review or between reviews.

The Self-Employment Income Report Form (SEIRF) (DES 2131) simplifies reporting income and expenses when earnings must be anticipated. It's modeled after IRS Form 1040, Schedule C, and can be used to report income for any type of business with any form of organization. However, some, especially farm operators, may find it easier to complete the IRS tax form when income and expense items are more complex.

To compute anticipated earnings, the person must complete a SEIRF for those months of operation since the change in circumstances occurred (remember, the beginning of a business is a change in circumstances). S/he may complete the SEIRF for each month separately or aggregate the months on one SEIRF.

1. For six or more months of operation since the change, calculate monthly average IM income and use it for the rest of the year.

2. For changes in months one through five, calculate monthly average IM income and the cumulative monthly average over six months of operation.

3. For less than one month of operation since the change, the person must estimate income and expenses for the next two months on a SEIRF. Divide the estimate by two to get monthly IM income for the first two months. Next, calculate the cumulative monthly average over six months of operation.

When there are less than six months of operation:

1. The person must complete a SEIRF for each month of operation and mail each SEIRF until s/he has reported six months of operation.

2. You must keep a cumulative monthly average of the IM income reported until the average covers six months.

   For example, at review, the person reports three months of operation and then receives and completes three SEIRFs. Total the IM income from the three SEIRFs and divide the total by three to get a monthly average. When you receive the fourth SEIRF:

   a. Add the IM income for the fourth month to total IM income for the first three months.

   b. Divide the result in a. by four to get the new cumulative monthly average.

This page last updated in Release Number : 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

4.2.6 Verification

Accept self-declaration of farm and self-employment income, except when any item is questionable (1.2.4).

If questionable, completed and signed IRS tax forms (4.2.2.2) are sufficient verification of farm and self-employment income. If anticipated earnings are used, a completed and signed SEIRF is sufficient verification.

It isn't necessary to collect copies of supportive items such as receipts from sales and purchases. However, you can require verification when the information given is in question. Document the reason for the request.

This page last updated in Release Number : 02-01
Release Date: 01-01-02
Effective Date: 01-01-02

4.2.7 Self-Employment Hours

Count the time a self-employed person puts in on business related activities involving planning, selling, advertising, and management along with time put in on production of goods and providing of services as hours of work.

This page last updated in Release Number: 02-01
Release Date: 01-01-02
Effective Date: 01-01-02

4.3 DEPENDENT CARE

4.3.1 Dependent care

Dependent care is paid care provided to a child and/or incapacitated adult when the child's caretaker (3.5.2) or the adult's spouse is elsewhere due to employment.

The deduction is limited to expenses paid by a member of the fiscal test group (FTG) on behalf of another FTG member. Don't give the deduction to excluded members of an AG. Allow the deduction for eligible members and test children.

4.3.1.1 Provider

Do not allow dependent care when the provider is in the MA group. When the care is provided by a group member, there's no actual reduction in the group's disposable income.
When the provider is the caretaker relative's natural, adoptive, or stepchild, allow the deduction only when all 4 conditions are met:

1. The provider doesn't live in the MA group's home.
2. The provider is age 18 or older.
3. The provider wasn't claimed as a dependent on the caretaker's last federal tax return.
4. A true employer/employee relationship exists between the provider and caretaker. The ES agency must determine the relationship between the provider and caretaker and if payments are being made.

4.3.1.2 Costs

Allow actual costs paid, up to:

1. $200 for each child under age 2 (through the month in which s/he turns 2), and
2. $175 for each adult and each child age 2 (for a whole month) or older.

4.3.1.3 Insufficient Income

When a person's earned income does not cover allowable costs, deduct the difference from the earned income of someone else in the MA group.

This page last updated in Release Number : 01-05
Release Date: 10/01/01
Effective Date: 07/01/01

4.4 MONEY FOR SCHOOL

4.4.1 Family MA Cases

In Family MA cases, disregard all student loans and grants regardless of source. This includes not only those which were formerly disregarded but also all other money derived from any other student loan or grant.

However, if a student has income from an internship or assistantship that is not part of work study or another student aid, count the income from the internship or assistantship as earned income.

Example: Clark is a journalism student. The University School of Journalism has arranged an internship for him to work 10 hours a week at The Daily Planet. The newspaper pays him $30 a week. Count this as earned income when you are determining Clark's eligibility.

Disregard stipends to HS students from the UW Upward Bound program, to encourage low income students to further their education.

See 4.4.3 for instructions on how to treat income that is earned under the Workforce Investment Act (WIA). The Job Training Partnership Act (JTPA) was replaced by the Workforce Investment Act on July 1, 2000.

This page last updated in Release Number :04-03
Release Date: 08-02-04
Effective Date: 08-02-04

4.4.2 Elderly/DisableD

For elderly/disabled cases, apply the disregards listed in 4.4.2.1 & 4.4.2.2. But count all other money that is derived from any other student loan or grant not listed below. Use the Student Financial Aids Report (HCF 16021) to obtain the type and amount of the student's aid package. Also use it to inform the student financial aids office of assistance granted.

See 4.4.3 for instructions on how to treat income that is earned under the Workforce Investment Act (WIA) .

4.4.2.1 Total Disregards

For elderly/disabled cases, totally disregard all of the following sources of money for education or training:

1. Supplemental Educational Opportunity Grant (SEOG),

2. Perkins Loans (formerly NDSL),

3. Federal Direct Student Loan Program (Formerly GSL & FFELP),
4. Wisconsin Direct Student Loan (WDL),
5. Talent Incentive Program/State Student
6. Incentive Grant (TIP/SSIG),
7. College Work Study Program (CWSP), and
8. Basic Educational Opportunity Grants (BEOG or PELL).
9. Wisconsin Indian Grant (WIG), and
10. Bureau of Indian Affairs Grant (BIAG).
11. Any other undergraduate loan or grant made or insured under any program administered by the U.S. Commissioner of Education.
12. Any other loans and grants obtained and used under conditions that prevent their use for current living costs.
13. County training program allowances granted by the ES agency.

4.4.2.2 Partial Disregards

For elderly/disabled cases, partially disregard all other money for education or training as follows:

1. Determine the cost of tuition, fees, books, transportation essential to education or training, and day care.
2. Subtract the total in "1" from the grant, loan, scholarship, etc. total.
3. Count any remaining money as unearned income:
    a. Only as of when the student gets the money; and
    b. Over the months the money is intended to cover. If, for example, the remaining $600 of a grant is intended to cover January through June and it's received in:
        - May, count $100 in each of the income months of May and June;
        - July, budget $0;

- December, count $100 in each of the income months of January through June.

This page last updated in Release Number :00-01
Release Date: 01-01-01
Effective Date: 01-01-01

4.4.3 Workforce Investment Act (WIA)

For both Family & Elderly/Disabled MA cases, disregard all unearned income from WIA to any adult or minor participating in WIA, including:

1. "Need-based payments" paid to persons as allowances to enable them to participate in a training program.

2. "Compensation in lieu of wages" paid to persons in "tryout employment". This is arranged when private-for-profit opportunities aren't available and is generally limited to persons under age 22. Ask any applicant under age 23, or the local WIA staff if s/he is participating in "tryout employment". If s/he is, count this as unearned income.

3. "Payments for supportive services" paid to persons in training programs who aren't able to pay for training related expenses (e.g., transportation, health care, child care, meals).

Earned WIA income is paid in the form of wages from on-the-job training (OJT) and work experience activities. Disregard all earned WIA income of a minor for up to a total of 6 months per calendar year. Negotiate with the MA group which 6 months of income to disregard. The 6 months need not be consecutive. Budget WIA income earned by a minor in other than these 6 months according to (4.1.5.9.)

Count the **earned** WIA income of adult participants.

The **Job Corps Program** is a part of WIA. Consider a minor who's participating in the Job Corps a student when you calculate the income disregards for full-time students, and part-time students who are not employed full-time.

Consider Job Corps payments to adult participants as unearned WIA income.

This page last updated in Release Number : 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

4.5 ASSETS

4.5.1 ASSETS INTRODUCTION

Apply the collection and verification (1.2) policies expressed in this section only to EBD MA cases.

Do not count income as an asset in the month it was received when determining the countable asset amount.

Example: Mr. Johnson has $2600.00 in his checking account for the month of March. Of that amount, $700.00 is unearned income that he received in March. His countable asset amount is $1900.00.

Add together all countable, available (4.5.2), assets the fiscal group owns including:

1. Joint accounts. (4.5.4.1)
2. Burial Assets (4.5.5)
3. Savings account
4. Checking account
5. Cash available
6. Stocks, bonds, CDs.
7. Loans (4.5.7.2)
8. Life Insurance (4.5.7.5)
9. Non- Burial Trusts (4.5.6)
10. Land Contract (4.5.7.12)
11. Mortgage (4.5.7.13)
12. Trailer Home (4.5.8.1.2)
13. Nonhome Real Property . (4.5.8)

This page last updated in Release Number : 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

4.5.2 AVAILABILITY

An asset is available when:

1. It can be sold, transferred, or disposed of by the owner or the owner's representative,

2. The owner has a legal right to the money obtained from sale of the asset,

3. The owner has the legal ability to make the money available for support and maintenance, and,

4. The asset can be made available in less than 30 days.

Consider an asset as unavailable if:

1. The client lacks the ability to provide legal access to the assets, and
2. No one else can access the assets, and
3. A process has been started to get legal access to the assets.

   or

   When the owner or owner's representative documents that the asset will not be available for 30 days or more.

Use the criteria above to determine whether an asset was available in a backdate month except, if an asset is deemed unavailable in the month of application because it will not be available for 30 or more days, it should be considered unavailable in any or all backdate months.

Example: Sylvia has life insurance that she cannot convert to cash within 30 days. She has a letter from the insurance company stating when she will receive the money. It becomes available the day she receives the money. Schedule an eligibility review, for no later than the 60th day after the date of application.

4.5.2.1 Real Property

Nonexempt real property (4.5.8) is unavailable when:

1. The person who owns the property lists it for sale with a realtor. See 4.5.9.
2. A joint owner who is outside the fiscal test group refuses to sell the property.

When the client is a co-owner of the property with someone outside the fiscal group, you must determine whether s/he is a joint owner or an owner-in-common.

Joint ownership has a right of survivorship. That is, upon the death of one joint owner, the other inherits the share of the deceased. A joint owner's share may not be sold without forcing the sale of the entire property.

Ownership-in-common has no right of survivorship. An owner-in-common may bequeath his/her share of the property to anyone s/he chooses. S/he may also sell his/her share during his/her lifetime.

If an institutionalized person owns property that's unavailable because it's listed for sale, s/he can use some of her income to maintain the property until it is sold. Allow minimal heat and electricity costs so as to avoid physical damage to the property while it is waiting to be sold. Also allow a minimum amount of property insurance coverage. But do not allow taxes and mortgage payments; they must be paid from the proceeds of the sale.

Allow the maintenance costs for as long as the person is making a good faith effort to sell the property, but in no case for longer than six months.

This page last updated in Release Number : 05-01
Release Date: 01-11-05
Effective Date: 01-11-05

4.5.3 SEPARATE & MIXED ASSETS

When an MA group keeps an exempt asset in:

1. A separate account or an account with other exempt assets, exempt the exempt asset:

    a. Indefinitely, for example, most payments to Native Americans (4.1.2.1), or

    b. For as long as the exemption can be applied to the asset, for example, EITC (4.5.7.8), which is exempt only through the month following the month of receipt.

2. An account mixed with other assets, some of which are non-exempt, exempt the exempt asset:

    a. For six months from the date the exempt asset was mixed with the non-exempt assets, or

    b. If the exempt asset has been prorated as income, exempt it for the period over which it is prorated.

This page last updated in Release Number : 02-01
Release Date : 01-01-02
Effective Date : 01-01-02

4.5.4 ACCOUNT

Account means a deposit of funds with a financial institution (bank, savings and loan, credit union, insurance company, etc.).

4.5.4.1 Joint Accounts

Apply the following policy to savings, checking and share accounts, certificates of deposit, NOW accounts, and similar arrangements where the holders have equal access to the funds.

Deem amounts from joint accounts differently depending upon if the account is shared with an EBD Medicaid applicant/recipient.

EBD Medicaid applicant/ recipients, include any of the Medicare Beneficiary programs QMB, SLMB, SLMB +, and QDWI.

SeniorCare applicant/recipients are not considered an EBD related applicant/recipient when deeming joint accounts.

4.5.4.1.1 EBD Medicaid Applicant/Recipient EBD co-owner

When an EBD Medicaid applicant/recipient shares a joint account with a co-owner who is another EDB applicant/recipient, deem an “equal share” to each account holder.

“Equal Share” means an amount in proportion to the number of EBD-related applicant/recipient account holders. If there are three holders, an equal share means each is deemed 1/3 of the account balance

4.5.4.1.2 EBD Medicaid Applicant/Recipient Non EBD Co-Owner

When an EBD Medicaid applicant/recipient shares an account with an individual or individuals who are not EBD Medicaid applicant(s)/recipient (s) deem the full share to the EBD Medicaid applicant/recipient.

Full share” means an amount equal to the account balance. The account balance is the total of the principle and any interest retained in the account, minus any withdrawal penalties or charges.

Applying the preceeding policy may result in considering available to a fiscal test group more money from a joint account than is actually in that account. If that occurs, deem an equal share to each account holder who is in the fiscal test group.

Example: Joe is an EBD Medicaid recipient who shares a $4000 account with his spouse Connie. Joe and Connie reside together and are therefore in the same Fiscal Test Group (FTG). Rather than assigning $4000 from this account as Joe’s asset and $4000 as Connie’s asset, which would result in $8000 being counted as the fiscal test group’s asset, deem an equal share to each account holder who is in the FTG so that only $4000 would be counted as the group’s total asset.

4.5.4.1.3 Exception to Joint- Accounts policy

Don’t apply Joint Accounts policies (4.5.4.1) to the following kinds of a joint accounts:

1. Accounts established for business , charitable or civic purposes.

2. Trust or restricted accounts. A trust or restricted account is one in which the person named as holder of the account has no access or limited access to the funds in it.

3. Special purpose accounts. A special purpose account has at least one holder acting as the power-of-attorney, guardian or conservator for at least one of the other holders of the account.

4. Convenience accounts. The following policy applies only to joint accounts of persons who are not married to one another:

When a person's name appears on a joint account, assume s/he is part owner of the assets in the account. Inform the client that s/he has a right to present evidence showing s/he did not deposit any assets into the account.

To show that s/he does not own or co-own any assets in the account, s/he must present all of the following:

1. A signed statement explaining:

   a. Who owns the funds in the joint account.
   b. The reason for establishing it.

c. Who made the deposits to the account.

2. A signed corroborating statement from the co-holder of the account.

3. A copy of the change in the account which removes his/her name or restricts his/her access.

If the co-holder is incompetent or a minor, obtain a statement from a knowledgeable third party. Then, decide whether to accept the person's statement. If you decide s/he is not a co-holder, apply the decision retroactively as well as prospectively. When no third party is available, document the reason.

4.5.4.2 Jointly Held Real Property

Apportion an equal share of any real property or any in -come derived from real property to each owner. To apportion, the equity or income must be available.

This page last updated in Release Number : 04-01
Release Date: 02-27-04
Effective Date: 02-27-04

4.5.5 BURIAL ASSETS

4.5.5.1 Burial Trusts

Exempt all burial trusts made in Wisconsin that are irrevocable by Wisconsin law, as noted in the trust agreement. If made in another state, exempt all that are irrevocable by the laws of that state. Refer any question about any state's law to your corporation counsel.

Interest and dividends are irrevocable if they accrue to irrevocable trusts and if the trust agreement specifies they are irrevocable. If the interest or dividends are irrevocable, exempt them. If interest or dividends are revocable, count them.

In non-spousal Impoverishment EBD Medicaid cases, each fiscal group member may have one or more irrevocable burial trusts, the total value of which may not exceed $3,000. (See 5.10.4 for information about burial assets for persons with a community spouse.)

4.5.5.2 Burial Insurance

A burial insurance policy is a contract whose terms preclude the use of its proceeds for anything other than the payment of the insured's burial expense. It is an insurance product sold by a state licensed insurance company, and is typically funded with an annuity or life insurance policy.

The ownership of the annuity or life insurance policy is irrevocably assigned by the policyholder to a funeral expense trust established by the insurance company. The trustee or trust administrator is required to pay all trust proceeds toward the policy holder's funeral expenses at the time of the policy holder's death. If a trust's proceeds exceed burial costs, the excess must revert back to the deceased person's estate.

A burial insurance policy is unavailable if:

1. It includes language that says it is irrevocable, and
2. It states that all of the proceeds must be used for burial expenses.

The purchase of a burial insurance policy that meets the above conditions is not a divestment because the purchaser is presumed to receive fair market value.

The following are not burial insurance policies:

1. If a policy has cash surrender value to which the client has access, the policy is not burial insurance it is life insurance.
2. If a burial policy calls for any excess proceeds to be paid to secondary beneficiary (other than the deceased person's estate), it is life insurance, not burial insurance.
3. Similarly, if a policy calls for the proceeds to be paid to a private party who is expected but not legally required to use the funds for the burial costs of the insured, the policy is life insurance.

4.5.5.3 Life Insurance Funded Burial Contracts (LIFBC)

A life insurance funded burial contract involves a person purchasing a life insurance policy on his or her own life and then assigning, revocably or irrevocably, either the proceeds or ownership of the policy to a third party, generally a funeral provider. The purpose of the assignment is to fund a burial contract.

Death benefits which exceed the actual costs of burial expenses must be paid to the insured's estate or the insured's beneficiary.

A burial contract that is funded with a life insurance policy must be in writing and must contain all of the following:

1. Name of funeral home and the insurer.
2. Statement of funeral goods and services.
3. Effect of canceling or surrendering the insurance policy.
4. Effect of changing the assignment of the policy proceeds.
5. Nature and extent of any price guarantees for goods and services.

The assignment option (revocable or irrevocable) chosen by the customer impacts the determination of countable asset and/or divestment amount.

4.5.5.3.1 Irrevocable Assignment of LIFBC

An irrevocably assigned LIFBC is an unavailable asset because the client no longer owns it.

If a client has chosen irrevocable assignment of his/her LIFBC the burial space exemption (4.5.5.4) may apply, depending on the nature of the contract. Any portion of the contract that represents the purchase of a burial space is exempt and has no effect on the burial funds exclusion (4.5.5.5).

If the face value of the burial funds portion of the contract exceeds $1,500, it offsets the burial fund exclusion described in 4.5.5.5.

If the face value of the burial funds portion does not exceed $1,500, determine the cash surrender value (CSV) and proceed in the following order:

1. Apply the CSV to burial spaces.
2. Apply the burial fund logic described in 4.5.5.5 to any remaining CSV.
3. Apply the CSV to any itemized goods or services, not accounted for by items #1 and #2 above, purchased at fair market value.
4. Apply divestment policy to any remaining CSV (4.7.13.2).

Example 1: Mr Atkins has irrevocably assigned the ownership of his life insurance policy to a funeral home to fund a burial contract. The face value of the LIFBC is $3,000. The Statement of Funeral Goods and Services shows $3,000 for the pre-arrangement of the funeral, of which $1,300 is designated for a casket and $1,700 for funeral expenses (services and cash advances for such things as flowers and the obituary). The $1,700 funeral expense portion reduces the $1,500 burial fund exclusion (4.5.5.5), and so $1,500 of this LIFBC will be considered his exempt burial fund. The $1,300 casket does not reduce the burial fund exclusion (4.5.5.5) and is not a countable asset because it is a purchase of a burial space.

Because the LIFBC was assigned irrevocably, determine if Mr. Atkins is receiving other goods or services at fair market value for the remaining $200 designated for funeral expenses. If he is not receiving goods or services at fair market value, consider the remaining $200 divestment (4.7.13.2).

If the face value of the LIFBC exceeds the total amount shown on the Statement of Funeral Goods and Services, determine the cash value and apply the divestment policy (4.7.13.2). Any portion of an irrevocably assigned LIFBC for which no goods and services are received at fair market value is the divested amount.

Example 2: Mr. Atkins has irrevocably assigned the ownership of his life insurance policy to a funeral home to fund a burial contract. The face value and the cash value of the LIFBC is $3,200. The Statement of Funeral Goods and Services shows $3,000 for the pre-arrangement of the funeral. A divestment in the amount of $200 occurred, because the cash value of the LIFBC exceeds the expenses of the pre-arrangement of the funeral.

4.5.5.3.2 Revocable Assignment of LIFBC

When a client has chosen revocable assignment of their LIFBC, use the following procedures to determine the countable asset amount.

Identify all other burial assets and life insurance policies the customer may have. Use burial fund logic (4.5.5.5) to determine what portion of the LIFBC is a countable asset.

The value of the burial contract is equal to the cash surrender value (CSV) of the life insurance policy. If the face value of all life insurance policies is $1,500 or less, exempt the CSV under the life insurance exclusion.

If the face value of all policies exceeds $1,500, treat the CSV of the policy according to the burial funds exclusion, if applicable.

If one or more burial spaces are included in the statement of funeral goods and services, the burial space exclusion (4.5.5.4) does not apply. This is because the provider has not received payment and therefore no purchase of burial space(s) has been made.

Example 1: Mrs. White has a revocably assigned LIFBC and no other burial assets or life insurance policies. The face value of the LIFBC is $3,000 and the CSV is $1,700. The total value of the LIFBC is equal to the CSV of $1,700.

The burial contract designates $1,300 for a casket and $1,700 for funeral expenses. The burial space exclusion (4.5.5.4) does not apply to Mrs. White's contract, but $1,500 of the CSV is exempt under the burial funds exclusion (4.5.5.5). The remaining $200 of the CSV is a countable asset.

Example 2: Mrs. White has a revocably assigned LIFBC. She additionally has a burial plot already paid for and a whole life insurance policy with a face value of $1,500 and cash surrender value (CSV) of $1,000. The face value of the LIFBC is $3,000 and the CSV is $1,700. The total value of the LIFBC is equal to the CSV of $1,700.

The burial contract designates $1,300 for a casket and $1,700 for funeral expenses. The burial space exclusion (4.5.5.4) does not apply to Mrs. White's contract. No portion of the CSV is exempt under the burial funds exclusion (4.5.5.5), because the face value of her whole life insurance policy is $1,500. The burial plot is exempt, because it is paid for. The entire value of the LIFBC ($1,700) is a countable asset.

4.5.5.4 Spaces

Burial space exemptions apply only to EBD fiscal group members. Burial space exemptions include the following, if they have been paid for:

1. Plots, vaults, caskets, crypts, mausoleums, urns, or other repositories customarily used for the remains of deceased persons, and

2. Necessary and reasonable improvements upon the burial space with items such as headstones, markers, plaques, and

3. Arrangements for opening and closing the gravesite.

Exempt multiple spaces of any value under the following conditions:

1. The space(s) must be owned by the EBD person, that person's spouse, or, when the EBD person is a minor, by the minor's parents.

2. Both a plot and a mausoleum space cannot be exempted for the same person.

3. Each person may have more than one type of space.

4. The space(s) must be for the use of the client or one of the following:

   a. Spouse.

   b. Minor or adult natural, adoptive, or stepchild.

   c. Brother or sister.

   d. Natural or adoptive parent.

   e. Spouse of any of the above.

Example : Bob, age 12, lives with his parents and is tested for EBD MA. His father owns five burial plots and spaces: #1 is for Bob, #2 and #3 are for his parents, #4 is for his older brother, who does not live at home, and #5 is for Bob's uncle. All the plots and spaces are exempt except #5.

4.5.5.5 Burial Funds

Burial fund exemptions apply only to EBD fiscal group members. Burial funds are funds that are set aside for burial expenses. EBD clients and their spouses may each have one burial fund.

To find the amount of a burial fund that can be exempted, add:

1. The face value of the person's irrevocable burial trusts.

2. The face value of all of his/her life insurance policies whose cash value is exempt.

3. The face value of his/her exempt burial insurance (4.5.5.2).

4. The cash surrender value of revocably assigned life insurance funded burial contracts (LIFBC) (4.5.5.3.2).

5. The burial funds portion of irrevocably assigned LIFBC (4.5.5.3.1).

If the total value of above items is $1,500 or more, do not exempt any more burial funds. If the total is less than $1,500, subtract the total from $1,500. The result of this subtraction is the amount of his/her burial fund total that is exempt.

Example 1: Mrs. Smith, age 74, applies for MA. She has a $1,600 savings account designated as a burial fund, a $1,300 irrevocable burial trust, and two life insurance

policies. The combined face values of the life insurance policies total $900. Add up the values of exempted assets. The irrevocable burial trust is exempt. The life insurance cash values are exempt when the total of their face values does not exceed $1,500.

$1,300	Irrevocable burial trust
+900	Face value life insurance
$2,200	

The total is more than $1,500 so no portion of the burial fund (savings account) is exempt.

Example 2: This time, Mrs. Smith, in addition to her $1,600 savings account designated as a burial fund, has a $300 irrevocable burial trust and two life insurance policies with a combined face value of $900.

$ 300	Irrevocable trust
+ 900	Face value life insurance
$1,200	

The total is less than $1,500, so determine what portion of Mrs. Smith's savings account can be exempted as a burial fund.

$1,500	Maximum burial fund exclusion
- 1,200	
$ 300	

Mrs. Smith can exempt $300 from her savings account as a burial fund. The remaining $1,300 is an available asset.

Anyone claiming a burial fund must sign a statement identifying the fund's location, type, amount, and account number. The statement must specify the month and year in which s/he first intended to set the fund aside for burial.

The fund can be excluded retroactively back to the first day of the specified month, but no earlier than November 1, 1982. It loses its exemption if it is used for anything other than the person's burial.

The fund set aside for burial must be identifiable, but not necessarily segregated from other funds.

This page last updated in Release Number : 05-01
Release Date : 01-11-05
Effective Date : 01-11-05

4.5.6 NON-BURIAL TRUSTS

A trust is any arrangement in which a person (the "grantor") transfers property to another person with the intention that the person (the "trustee") hold, manage, or administer the property for the benefit of the grantor or of someone designated by the grantor (the "beneficiary").

The term “trust” includes any legal instrument or device or arrangement, which, even though not called a trust under state law, has the same attributes as a trust. That is, the grantor transfers property to the trustee and the grantor's intention is that the trustee hold, manage, or administer the property for the benefit of the grantor or of the beneficiary.

The grantor can be:

1. The MA client.

2. His/her spouse.

3. A person, including a court or an administrative body, with legal authority to act in place of or on behalf of the client or the client’s spouse. This includes a power of attorney or a guardian.

4. A person, including a court or an administrative body, acting at the direction or upon the request of the client or the client’s spouse. This includes relatives, friends, volunteers or authorized representatives.

4.5.6.1 Trust Principal

The trust principal is the amount placed in trust by the grantor plus any trust earnings paid into the trust and left to accumulate.

4.5.6.2 Revocable Trusts

A revocable trust is a trust which can be revoked, canceled or modified by the grantor or by a court. A trust which is called irrevocable, but which will terminate if some action is taken by the grantor, is considered a revocable trust.
The trust principal of a revocable trust is an available asset.

4.5.6.3 Irrevocable Trusts

An irrevocable trust is a trust that cannot, in any way, be revoked by the grantor. The trust principal of an irrevocable trust is not an available asset.

Note: If the grantor is an institutionalized person , or some-one acting on behalf of an institutionalized person, setting up an irrevocable trust may be a divestment (4.7.13.2) and (4.7.13.3).

4.5.6.4 Special Needs Trust

If the Special Needs Trust is an irrevocable trust, follow the policy outlined in 4.5.6.3. Disregard special needs trusts whose sole beneficiary is under age 65 and totally and permanently disabled (under SSI program rules) if it meets these conditions:

1. The trust must be established for the sole benefit of the disabled person by his/her parent, grandparent, legal guardian or a court, and

2. Contain a provision that, upon the death of the beneficiary, the Wisconsin MA program will receive all amounts remaining in the trust not in excess of the total amount of MA paid on behalf of the beneficiary.

The exception continues after the person turns 65, provided s/he continues to be disabled. However, a grantor cannot add to the trust after the beneficiary turns 65. Anything added to the trust after the beneficiary turns 65 is a divestment. Money added before the beneficiary turns 65 is not a divestment

4.5.6.5 Pooled Trusts

Disregard pooled trusts for disabled persons. They must meet the following conditions:

1. Established and managed by a non-profit association.

2. A separate account is maintained for each beneficiary. For purposes of investment and management, the funds from separate accounts may be pooled together.

3. The sole beneficiaries are persons determined disabled under SSI program rules.

4. Contain a provision stating that upon the death of the beneficiary the trust will use remaining funds in the account to reimburse the Wisconsin MA program.

This page last updated in Release Number : 02-03
Release Date: 07-01-02
Effective Date: 07-01-02

4.5.7 LIQUID ASSETS

4.5.7.1 Personal Property

Personal property in general includes money, goods, cause of action, damages for breach of contract, and evidences of debt. Value of personal property means market value. Deduct all encumbrances to arrive at a final evaluation. Count household effects, libraries, and jewels only if of unusual value.

4.5.7.2 Loans

If an AG member receives a loan and it is available for current living expenses, count it as an asset. Do this even if there is a repayment agreement. If it is not available for current living expenses, disregard it.

If an AG member makes a loan (except a land contract), treat the repayments as follows:

1. Count any repayments toward the principal of the loan, whether it is a full payment, a partial payment, or an installment payment, as an asset.

2. Count any interest payment on the loan as unearned income in the month received, and as an asset in the months following the month it was received.

4.5.7.2.1 Reverse Mortgage

A reverse mortgage loan is a loan, or an agreement to lend, which is secured by a first mortgage on the borrower's principal residence. The terms of the loan specify regular payments to the borrower. Repayment (through sale of the residence) is required at the time all the borrowers have died, or when they have sold the residence or moved to a new one.

Treat reverse mortgage loan payments to the borrower as assets in the month received and thereafter. Do not count undisbursed funds (not yet paid to the borrower) as assets. They are considered equity in the borrower's residence.

4.5.7.3 HUD Payments

Disregard reimbursements resulting from federal regulatory changes in computing U.S. Department of Housing and Urban Development (HUD) housing rent as income in the month paid and assets in the next month.

4.5.7.4 Annuities

An annuity is a written contract under which, in return for payment of a premium or premiums, an individual will receive a series of payments at regular intervals for a specified time period.

The annuitant is the person entitled to the payments. A purchaser can name himself/herself or another person as the annuitant. The purchaser may also name a beneficiary to receive annuity payments after the annuitant's death.

4.5.7.4.1 Annuities purchased after March 1, 2004

(For annuities purchased before March 1, 2004 refer to subsection 4.5.7.4.2)

Treat Annuities purchased after March 1, 2004 as available assets in accordance with the following:

Annuities that can be surrendered:

If the annuity's cash value is available for withdrawal (minus any penalty) the annuity can be "surrendered."

To determine the value of annuities that can be surrendered (for example, an annuity in the accumulation phase), use the following formula:

1. Total deposits made to the annuity. **Plus** 2. Earnings on the deposits not previously paid out. **Minus** 3. Withdrawals and surrender costs charged for withdrawal. **Equals** 4. Annuity's value

Annuities that cannot be surrendered.

Determine the value of annuities that cannot be surrendered (e.g. immediate annuities in the payout phase) as follows

1. Total deposits made to the annuity. **Plus** 2 Earnings on the deposits not previously paid out **Minus** 3. Payouts **Equals** 4. Annuity's Value

Applicants/recipients who own annuities that **cannot be surrendered** will be provided an opportunity to prove that the annuity is unavailable. (**Note**: This does not apply to annuities that can be surrendered) The annuity will be considered to be an unavailable asset **only** if documentation is provided from at least three companies active in the market stating their unwillingness to purchase the annuity. Payments from an annuity that is considered to be unavailable must be counted as income. Annuities that are considered to be unavailable must also be evaluated for possible divestment, in accordance with (4.7.11).

The applicant/recipient may prove that the annuity has a fair market value lower than the initial value determined by the worker. The applicant/recipient must provide documented offers from at least three companies active in the market and do so within the regular timeframe. The fair market value of the annuity will be established as the highest of the documented offers. An offer from someone not active in the market will be considered legitimate only if it meets or exceeds the three offers from companies active in the market.

To provide proof that the annuity is unavailable or has a fair market value lower than the initial value determined by the worker, the applicant must demonstrate that (s)he has made reasonable attempts to obtain a fair market price for the annuity contract or annuitized payments. The actual fair market value would be established by offering the annuity for sale in an “arms-length transaction” to at least three companies active in the annuities market.

An “arms length transaction” is one in which the buyers and sellers of a product act independently of each other and have no personal relationship.

Example 1: Cynthia is 83 years old and applying for MA. She owns an annuity purchased after March 1, 2004. The annuity is paying out and cannot be surrendered. It is irrevocable and non-transferable. Still, the annuity will be treated as an available asset, unless Cynthia shows that it cannot be sold on the open market (i.e. has no fair market value). The worker determines an initial value for the annuity by applying the following formula:

1. Total deposits made to the annuity.

Plus

2. Earnings on the deposit not previously paid out

Minus

3. Payouts

Equals

4. Annuity’s Value

Rather than use this value to determine her MA eligibility, Cynthia prefers to establish a fair market value. She does so by offering her annuity for sale to three companies active in the annuities market. She obtains three written offers and provides this documentation to her worker. Her worker establishes the fair market value of the annuity as the highest of the three offers. The fair market value of the annuity is used to determine Cynthia’s MA eligibility. Enter the value on AALA with the MQ code.

Initial Processing
When Cynthia originally applies, calculate the value of the annuity using the formula described above. Enter the amount on the liquid asset screen AALA as type MQ and mark it as available. The asset will count for EBD MA subprograms only.

Market Value Pursued:
When Cynthia returns with the three written offers, tran to AALA for the previously entered MQ asset and change the amount to the highest of the three offers.

Example 2: Sam is 66 years old and applying for Medicaid. He owns an annuity purchased after March 1, 2004. The annuity is paying out and cannot be surrendered. It is irrevocable and non-transferrable. Still, the annuity will be treated as an available asset, unless Sam shows that it cannot be sold on the open market (i.e. has no fair market value). The worker determines an initial value of the annuity by applying the following formula:

1. Total deposits made to the annuity.

Plus

2. Earnings on the deposits not previously paid out.

Minus

2. Payouts

Equals

4. Annuity's Value

Rather than use this value to determine his eligibility, Sam prefers to establish a fair market value for the annuity. He attempts to do so by offering the annuity for sale to three companies active in the annuities market, but none of the companies is willing to purchase the annuity. Sam obtains letters from each of the three companies documenting their unwillingness to purchase the annuity. He provides the letters to his worker and, in doing so, has shown that the annuity cannot be sold. His worker treats the annuity as an unavailable asset in determining his Medicaid eligibility.

Initial Processing

When Sam originally applies, calculate the value of the annuity using the formula described above. Enter the amount on the liquid asset screen AALA as type MQ and mark it as available. The asset will count for EBD Medicaid subprograms only.

Market Value Pursued:

When Sam returns with the three letters declining to purchase, tran to AALA for the previously entered MQ asset and mark the asset as unavailable. Enter the monthly payment on AFUI as unearned income as type AN.

Example 3: Sherrie is 43, has a disability and is applying for MA. She owns an annuity purchased after March 1, 2004. The annuity is paying out and cannot be surrendered. It is irrevocable and non-transferrable. Still, the annuity will be treated as an available asset, unless Sherrie shows that it cannot be sold on the open market (i.e., has no fair market value). The worker determines an initial value of the annuity by applying the following formula**:**

1. Total deposits made to the annuity.

   Plus

2. Earnings on the deposits not previously paid out.

   Minus

3. Payouts.

   Equals

4. Annuity's Value

Rather than use this value to determine her MA eligibility, Sherrie prefers to establish a fair market value. She attempts to do so by offering her annuity for sale to two companies active in the annuities market, plus Frank, her nephew. She obtains three written offers (two from companies active in the market and one from Frank) and provides this documentation to her worker. Frank's offer is the highest of the three, however it may not be used to establish a fair market value for the annuity because it has not been compared to three offers from companies active in the market. Sherrie's MA eligibility is determined using the value of the annuity as initially established by the worker using the above formula.

Initial Processing
When Sherrie originally applies, calculate the value of the annuity using the formula described above. Enter that amount on the liquid asset screen AALA as type MQ and mark it as available. The asset will count for EBD MA only.

Market Value Pursued
Since Sherrie can only provide two offers from companies active in the annuities market her MA eligibility is determined using the value of the annuity as initially established. So, the offers are not considered and the same amount calculated previously and entered on AALA is still valid and not changed.

4.5.7.4.2 Annuities Purchased before March 1, 2004

Annuities that can be surrendered (In the payout phase)

The accumulation phase of an annuity is the period when the purchaser puts money into the annuity. During the accumulation phase, an annuity is an available asset because the annuitant can cash it in for its cash value.

Cash value (also known as surrender value) equals:

1. Total deposits made to the annuity.
   +
2. Earnings on the deposits not previously paid out.
   -
3. Withdrawals and surrender costs charged for withdrawal.

In determining the cash value, do not deduct income tax withheld or tax penalties for early withdrawal.

Annuities in the Pay-Out Phase (can not be surrendered)

The pay-out (annuitization) phase begins at the time payments start going to the annuitant in accordance with the settlement option. The settlement option specifies the way the funds from the annuity will be paid out. It involves choosing the amount of each payment, how often payments will be made, and the length of time over which the payments will be made.

An annuity becomes an unavailable asset on the date the settlement option is made final. This means even if the payment starts months later, it is unavailable on the date the settlement option is made final.

4.5.7.5 Life Insurance

Face value is the basic death benefit of the policy exclusive of dividend additions or additional amounts payable because of accidental death or under other special provisions. Cash value means the net amount of cash for which the policy could be surrendered after deducting any loans or liens against it.

Count the cash value of all life insurance policies. For persons age 65 or over, blind or disabled, count it only when the total face value of all policies owned by each person exceeds $1,500. Do this calculation for each EBD person. In determining the face value, do not include any life insurance which has no cash value.

Life insurance policies always have a face value, but do not always have a cash value. Term life insurance is limited to a defined time period as stated in the policy and does not usually have cash value. Group life insurance is usually term insurance and usually has no cash value. An endowment insurance plan generally has cash value.

4.5.7.6 Endowment to CCRC

Frequently, in order to enter a continuing care retirement community (CCRC), a person must pay a large, one-time entrance fee as an endowment. In exchange for this and, sometimes, an additional monthly payment, the person is promised care for the rest of his/her life, unless s/he chooses to move.

Endowments such as this are unavailable assets.

4.5.7.7 Income Tax Refunds

Federal and state income tax refunds are available assets.

4.5.7.8 Earned Income Tax Credit (EITC)

Disregard all Earned Income Tax Credit (EITC) payments in the month received and in the month after receipt.

After the “month received’ and the “month after receipt” have passed, count the EITC payment as an available asset.

4.5.7.9 Vehicles

A vehicle is any:

1. Passenger car or other motor vehicle, and
2. Used to transport persons or goods, and
3. Owned by someone in the fiscal test group.

In all cases, log skidders (used to move logs out of the woods to market) are exempt vehicles.

4.5.7.9.1 Determining Equity Value

Equity value is:

1. The vehicle's wholesale value as given in a standard guide on motor vehicle values (blue book), or the value as estimated by a sales representative at a local dealership,

2. Minus any encumbrances (loans or mortgages) that are recorded on the vehicle’s title as liens.

Do not increase a vehicle's value by adding the value of low mileage or other factors, such as optional equipment or apparatus for the handicapped.

Occasionally, a vehicle has more than one owner. Some of the owners may be in the fiscal test group, others not. To find what the fiscal test group’s equity value in the vehicle is, do the following:

1. Find the vehicle’s wholesale value.

2. Subtract the encumbrances (loans or mortgages) that are recorded as liens on the vehicle’s title. The result is the equity value.

3. Divide the equity value by the total number of owners.

4. Add up the prorated equity values of the owners who are in the fiscal test group. The result is the fiscal test group’s equity value in the vehicle.

4.5.7.9.2 When to Count, When to Exempt

Count vehicle values as follows:

For EBD categorically and medically needy MA, when the fiscal group owns:

1. One vehicle, exempt it if it meets one of the following conditions:

    a. Necessary for employment.

    b. Necessary for medical treatment of a specific or regular medical problem.

    c. Modified for operation by or transportation of a handicapped person.

    d. Necessary because of climate, terrain, distance or similar factors to provide transportation to perform essential daily activities.

    e. Disregard one vehicle for a spousal impoverishment case. (5.10.4)

2. One vehicle and it does not meet any of the above conditions, exempt it if its fair market value does not exceed $4,500. Fair market value in excess of $4,500 counts toward the asset limit.

3. Two or more vehicles, count the full equity value of all vehicles except for the one vehicle that meets the conditions of either #1 or #2 above.

4.5.7.10 Property Settlement

Money received as a property settlement is always an asset regardless of whether it is paid in one payment or in installments. It is never income.

4.5.7.11 Lump Sums Payments

Lump sum payments (rather than recurring payments) from such sources as insurance policies, sale of property, Railroad Retirement, Unemployment Compensation benefits, and retroactive corrective financial aid payments are counted as an asset when received.

4.5.7.11.1 Retroactive SS Payments

The unspent portion of retroactive SSI and RSDI benefits received on or after March 2, 2004 is excluded from resources for the 9 calendar months following the month in which the individual receives the benefits.

Do not count a retroactive social security or SSI payment as an asset either in the month of receipt or 9 months following the month the payment is received. A retro-active payment means it is paid later than the month in which it is due. After 9 months, treat any remaining available portion as an asset.

During the nine months in which it is not counted, the unspent portion of the payment can be mingled with other funds, provided it can be distinctly and separately identified.

The unspent portion of retroactive SSI and RSDI benefits received before March 2, 2004 is excluded from resources for the 6 calendar months following the month in which the individual receives the benefits.

4.5.7.12 Land Contract

When a land contract is executed, the purchaser builds equity in the property through the payments s/he makes. The seller keeps legal title to the property until it is paid for. The seller's interest in the land contract is personal property, not real property.

The seller's legal title to the property can be sold and converted to cash for support and maintenance. To determine the value of the seller's legal interest in the land contract:

1. Find the original sale price or the fair market value (as determined by a

qualified real estate appraiser). Of these two amounts choose the one which more accurately reflects the contract's true value on the date it was originated.

2. From this amount subtract:

a. Payments which the purchaser has already made on the principal.

> **Example 1:** The fair market value of the land contract is $50,000. The purchaser has already paid $10,000 on the principal.
> $ 50,000 Fair Market Value
> -10,000 Already Paid
> $ 40,000 Outstanding Balance

.

b. Encumbrances on the contract, for example, a personal loan.

c. The amount lost to a discount.

> **Example 2:** Milton Rokeach wants to buy up Mr. Graham’s land contract. He asks for a 10% discount.
>
> $40,000 Outstanding Balance
> - 4,000 10% Discount Given by Mr. Graham to Milton Rokeach
> $36,0000 Value of Mr. Graham’s Interest in the Land Contract

3. The remainder, after subtracting a., b., and c. from the original sale price, is the value of the seller's interest in the land contract. Count this as an available asset.

If the land contract is not an available asset, the person must document its unavailability by showing that either:

a. The terms of the land contract prohibit its sale, or

b. No one is willing to purchase it from him/her.

When the claim is that no one will purchase the land contract, it must be offered for sale to at least one individual or organization active in the land con-tract purchasing market. A written statement from the individual or organization that they will not buy it is sufficient to establish the land contract as an unavailable asset.

Notice that if it has been offered only to an individual or organization that never purchases land contracts, it remains an available asset.

4.5.7.13 Mortgage

Treat any mortgage held by and owed to a client the same as a land contract.

4.5.7.14 Wisconsin Higher Education Bonds

The State of Wisconsin sells Wisconsin Higher Education Bonds to the public as a way to save for higher education. To determine their net value, subtract broker's fees from market value.

The bonds may be sold back to the State, under certain time restraints:

1. Before the maturity date, a portion of their value is withheld. The amount withheld equals the school's tuition and fees. Any excess goes to the person.

2. On or after the maturity date, the value is the total amount received.

The bonds may be sold on the "secondary" bond market at any time. Since they can be disposed of on the market with no time limit they are an available asset. To determine their net value, subtract broker's fees from market value. (Verify the amounts through a broker.)

4.5.7.15 Wartime Relocation of citizens

Disregard restitution paid under PL 100-383 to Japanese-Americans and Aleuts or their survivors who were interned or relocated during World War II.

4.5.7.16 Agent Orange Settlement Fund

Disregard payment received from the Agent Orange Settlement Fund or any other fund established in settling “In Re: Agent Orange product liability Settlement Fund litigation, M.D.L. No. 381 (E.D.N.Y.)”. Disregard as income in the month received and as an asset thereafter.

4.5.7.17 Radiation Exposure Compensation Act

Disregard payments from any program under the Radiation Exposure Act (PL 101-426) paid to persons to compensate injury or death resulting from exposure to radiation from nuclear testing ($50,000) and uranium mining ($100,000).

When the affected person is dead, payment is made to his/her surviving spouse, children, parents, or grandparents. The federal Department of Justice reviews the claims and makes the payments.

Apply this disregard retroactively to October 15, 1990 and continue to disregard the payment for as long as it is identified separately.

4.5.7.18 Institutionalized Person’s Assets

An institutionalized person 's personal allowance may accumulate to where s/he may lose eligibility due to excess assets. To prevent this, s/he can spend money on personal needs or make a refund to the agency. If s/he chooses to refund the agency, calculate what a year's accumulation will be and work out a payment schedule. When the payments equal MA benefits received, have the person stop the payments until s/he receives more benefits.

If the person refuses to refund, discontinue eligibility when the asset limit is exceeded. S/he remains ineligible until the assets are again at or below the limit. At that point s/he may reapply.

These instructions apply to all institutionalized MA recipients, whether certified by your agency or by the Social Security Administration.

4.5.7.19 Blind/Disabled Set-Aside

Disregard the following for a blind or disabled person:

1. Assets essential to the continuing operation of her/his trade or business .

2. Other income-producing property.

3. Assets set aside to carry out an approved self-support plan (4.1.3.2.2). The set-aside must be segregated from other funds. Disregard interest that accumulates, provided the set-aside does not exceed the provisions of the plan.

4.5.7.20 Replacing and Repairing Exempt Assets

Vehicles and homes are examples of exempt assets. If an exempt asset is lost, stolen, or damaged, disregard any cash (and interest earned) or in-kind replacement received from any source to repair or replace it.

The cash or in-kind payment must be used within nine months of the date it is received. After the end of the ninth month, count as an asset leftover cash not used for the repairs or replacement.

Extend the nine-month period for up to another nine months if the person has good cause for not repairing or replacing the thing. Good cause means circumstances beyond the person's control to prevent repair or replacement. This includes not being able to contract it out. When there is good cause, count as an asset any amount not used for repairs or replacement. Begin with the month after the end of the extension.

If, during a good cause extension, the person no longer intends to replace or repair the exempt asset, count the amount for replacement or repair as an asset. Begin with the month the person reports his/her change of intent.

4.5.7.21 Retirement Benefits

Retirement benefits include work-related plans for providing income when employment ends (e.g. pension disability or retirement plans administered by an employer or union).

Other examples of retirement funds include accounts owned by the individual, such as Individual Retirement Accounts (IRA) and plans for self-employed individuals, sometimes referred to as KEOGH plans.

1. Employment related pension plans should be treated as follows.

    a. If an applicant/recipient has the ability to cash in a work related benefit, the net amount of the benefit (after any penalties but before any tax withholding) available to the applicant/recipient should be treated as an available asset. Some retirement benefit plans allow employees to cash in their benefits as a lump sum payment when they leave their job instead of waiting until they reach retirement age to get the pension. However, do not count retirement funds as an available asset if the applicant/recipient has to quit a job to get at the retirement funds, or if the applicant/recipient is receiving periodic payments from the retirement benefit plan.

    b. If the applicant/recipient does not have access to the account's principal in his/her retirement benefit plan, the principal should be treated as an unavailable asset.

    c. Periodic payments made from a work-related retirement benefit plan should be counted as income in the month of receipt.

2. Individually owned retirement funds, such as IRA's Keogh plans, etc., that are owned by the applicant/ recipient should be counted as available non-exempt assets (minus any early withdrawal penalty) for the Medicaid applicant/recipient. The applicant/recipient always has access to the principal in these accounts, subject to an early withdrawal penalty.

    Any periodic payments from these accounts should not be counted as income in the months of receipt. These payments are considered assets. They are considered the same as withdrawals from an applicant's saving account. Only interest earned on the funds in a retirement fund is to be counted as income (4.1.4.9).

3. Disregard work-related retirement benefit plans or individually owned retirement accounts, such as IRAs or Keoghs, of an ineligible spouse in an EBD case. Disregard work-related retirement benefit plans or individually owned retirement benefit plans or individually owned retirement accounts, such as IRAs or Keoghs, of an ineligible parent in a Disabled Minor case (1.1.3.1.2) This policy includes the disregard of retirement funds held by

the community spouse in spousal impoverishment cases.

Consider IRAs, Keoghs, or other retirement funds that are completely cashed in as a conversion from one asset form to another.

Example 1: Mike withdraws $2,000 he has in an IRA, and deposits it into a savings account. Continue to treat the $2,000 as a countable asset. This is just a conversion from one form of an asset to another. Treat any interest that Mark receives as income in the month received.

4.5.7.22 Gifts

A gift is something a person receives which is not repayment for goods or services the person provided and is not given because of a legal obligation on the giver's part. To be a gift, something must be given irrevocably (that is, the donor relinquishes all control).

Treat non-cash gifts as an asset, as you would an asset of a similar type. A cash gift is **income** in the month of receipt. It is an **asset** in the months after the month of receipt. Disregard cash gifts (such as for birthdays, graduation, and Christmas) that total $30 or less, for each assistance group member, for each calendar quarter.

4.5.7.23 U.S. Savings Bonds

Count the cash value of a U.S. Savings Bond unless it is unavailable. A bond is unavailable only if the MA group proves it tried to cash the bond and was refused.

4.5.7.24 Zebley Payments

Disregard all SSI payments received by anyone as a result of the Zebley v. Sullivan decision. Do not count it as income or a lump sum in the month received. Do not count it as an asset even if the family keeps the money and does not spend it.

4.5.7.25 Indian Judgment Fund Purchases

Disregard assets purchased with Indian judgment funds (4.1.2.1, #10). But do not disregard:

1. Proceeds from the sale of these initial purchases.
2. Subsequent purchases made with the proceeds from the sale of these initial purchases.

4.5.7.26 Payments to Nazi Victims

Disregard payments made under PL 103-286 to victims of Nazi persecution.

4.5.7.27 Spina Bifida Child

Disregard payments made under PL 104-204 to any child of a Vietnam veteran for any disability resulting from the child's spina bifida.

4.5.7.28 Uniform Gifts to Minors Act

Count funds held in an account for the benefit of a minor that are the result of transfers under the Uniform Gifts to Minors Act. This act is also called the Uniform Transfers to Minors Act. The funds are available when determining eligibility for the minor unless a court determines otherwise.

4.5.7.29 Individual Development Accounts (IDA) Programs

Individual Development Accounts (IDA) are restricted accounts owned by low-income people. The IDA program provides matching funds for buying a home, starting a business, or post-secondary education. Client savings and interest are a countable asset if the IDA was established using the Assets for Independence Act or Refugee Assistance Act funds. However, if W-2 or Community Reinvestment funds support the IDA program, the assets are exempt.

4.5.7.30 Crime Victim Restitution Program

Disregard any payments received from a state established fund to aid victims of a crime. These payments are an excluded resource for 9 months following the month of recipient.

This page last updated in Release Number : 05-01
Release Date: 01/11/05
Effective Date: 01/11/05

4.5.8 REAL PROPERTY

Real property means land and most things attached to the land, such as buildings and vegetation.

4.5.8.1 Home/Homestead Property

A home is a place of abode and lands used or operated in connection with it. In urban situations the home usually consists of a house and lot. A home can consist of a house and more than one lot. As long as the lots adjoin one another, they are considered part of the home.

Homestead property may have more than one building or house on it. This applies to urban home owners as well as farm families. In farm situations the home consists of the house and buildings together with the total acreage property upon which they are located that is considered a part of the farm. There will be farms where the land is on both sides of a road and considered a part of the home.

Land should be considered part of the home property if it is not completely separated from the home property by land in which neither the individual nor his/her spouse has an ownership interest.

Easements and public rights of way (utility lines, roads, etc) do not separate other land from the home plot.

If land is completely separated from the home property by land in which neither the individual nor his/her spouse has ownership interest it should not be considered part of the homestead property

4.5.8.1.1 Multiunit Dwelling

When a MA fiscal group member lives in one unit of a multi-unit dwelling and owns all of the units, exempt all of the units and the property they are on. Consider the whole multiunit dwelling as the group member's home.

4.5.8.1.2 Non-Motorized Trailer Homes

A non-motorized trailer home is considered real property (4.5.8), regardless of whether or not the client owns the land that it is on. Consider the non-motorized trailer home:

1. Home property (4.5.8.1) if the client currently lives in it or had lived in it before entering an institution, or

   If the client owns the land that the non-motorized home is sitting on, consider it and any other buildings on that land as part of the homestead.

2. Non-home property if the client does not live in it or had not lived in it prior to entering an institution.

   If the non-motorized trailer home is listed for sale, it is considered unavailable (4.5.2)

4.5.8.1.3 Exempt Home Property

Although home property is an exempt asset under the conditions described in this subsection, there are limits on divesting home property (4.7.2.3.1).

Non-Institutionalized Person. For a person who is not residing in an institution, the home is exempt as long as the person resides in it, or intends to return to it. There is no time limit for an intended return. The home remains exempt even if the person rents out part of it while s/he continues to reside there.

Institutionalized Person . When a person resides in an institution, the home is exempt if one of the following conditions is met:

1. His/her spouse or dependent relative resides in the home.

The dependency of the relative may be of any kind, such as financial or medical.

The relative may be father, mother, daughter, son, grandson, granddaughter, in-laws, stepmother, stepfather, stepson, stepdaughter, grandmother, grandfather, aunt, uncle, sister, brother, stepbrother, stepsister, half-sister, half-brother, niece, nephew, or cousin.

2. The institutionalized person expresses his/her intent to return to the home. If s/he is able to form an intent but unable to express it, determine his/her intent through other available evidence. Other evidence includes:

    a. His/her written statements.

    b. His/her oral statements made before incapacitation. Accept reports of these statements made by family members.

    c. Accept reports of his/her intent made by an authorized representative (IMM, Ch. I, Part A, 18.3.0). If there is no evidence s/he disagrees with the statement, accept the authorized representative's statement.

       If s/he appears unable to form an intent but has not been judged incompetent by a court, accept a family member's statement as evidence of his/her intent.

       If s/he has been judged incompetent, accept the intent statement of his/her guardian. Use the guardian's intent statement even if it differs from the client’s.

If neither condition #1 nor #2 is met, the property is no longer the principal residence and becomes non-home property.

4.5.8.1.4 Sale of Home Property

Money from the sale of real property is an asset. When the property that is sold is a homestead, disregarded the proceeds if they are placed in an escrow account and used to purchase another home within three months.

4.5.8.1.5 Life Estate

A life estate allows an individual to gift a home or other possession but retain certain property rights for his/her lifetime. Generally a life estate provides an individual the right to possess and use a gifted property, and to make money from it. The person does not have the title to or the right to sell the property. S/he usually may not pass it on to his/her heirs as an inheritance. S/he also has the right to sell his/her interest in it. S/he is liable for all costs of the property such as taxes and repairs, unless s/he moves off the property or the will (or deed) states otherwise.

When property is conveyed to one person for life (life estate holder) and to another person (the remainder man), both a life estate interest and remainder interest are created. When the life estate holder dies, the remainder man holds full and unconditional title to the property and can dispose of it as s/he wishes (fee simple). Life estate values need to be determined for divestment calculation.

Example: Sidney gifted away his $100,000.00 home to his nephew Frank, but retained a $30,000.00 life estate, the divested amount is $70,000.00.
The life estate interest is an unavailable asset when determining Medicaid asset eligibility for Sidney. However, the remainder interest is an available non-exempt asset for Frank, the remainder person, for Medicaid eligibility determinations.

Determine the value of the remainder interest for the date you are determining Medicaid eligibility. To do this you need to use the age of the life estate holder on the date that you are determining eligibility for the remainder person. Also use the property's FMV as of that same date. Then select the remainder multiplier (the one that corresponds to the age of the life estate holder) from the life estate table and multiply the FMV by that number. Your result should be the value of the property's remainder interest for the remainder person as of the date that you are determining that person's Medicaid eligibility.

To determine the value of a life estate or remainder interest:

1. In the Life Estate and Remainder Interest Table (8.1.2) find the line for the person's age as of the transaction date.

2. Multiply the figure on that line in the Life Estate or Remainder column times the fair market value to determine the value of the life estate or remainder interest.

When a life estate holder moves off the property and the property is rented, follow the instructions in 4.1.5.3 for counting the rental income.

If a remainder person sells the property for which a life estate is retained, the life estate holder is not entitled to any of the payments.

However, if the life estate holder gives up his/her life estate to secure the sale of the property, then the life estate holder would be entitled to some portion of the proceeds from the sale of the property. Treat money received as a result of property settlement as an asset (4.5.7.10).

This page last updated in Release Number : 05-01
Release Date: 01/11/05
Effective Date: 01/11/05

4.5.9 EBD NON-HOME PROPERTY EXCLUSIONS

Non-home property is any countable asset other than a homestead. See 4.7.4 for divestment. Exclusions of non-home property in EBD cases include:

1. Real property that is listed for sale with a realtor at a price consistent with its fair market value.

2. Property excluded regardless of value or rate of return. Property used in a trade or business is in this category. See 4.2.3.1.1.

3. Property excluded up to $6,000, regardless of rate of return. This category includes non-business property used to produce goods or services essential to self-support. Any portion of the property's equity value in excess of $6,000 is not excluded.

   Non-business property essential to self-support can be real or personal property. It produces goods or services essential to self-support when it is used, for example, to grow produce or livestock solely for personal consumption, or to perform activities essential to the production of food solely for home consumption.

4. Property excluded up to $6,000 if it is non-business property that produces a net annual income (either cash or in-kind income) of at least 6%.

   If the excluded portion produces less than a 6% return due to circumstances beyond the person's control (e.g., crop failure, illness), and there is reasonable expectation that it will again produce at least a 6% return, continue to consider the first $6,000 in equity as excluded.

This page last updated in Release Number: 02-04
Release Date: 10-01-02
Effective Date:10-01-02

4.5.10 INDIAN LANDS

Exclude a Native American's interest in or possession of land which is held by an individual Native American or tribe, and which can only be disposed of with the approval of other individuals, the tribe, or the Federal government.

This page last updated in Release Number: 02-04
Release Date: 10-01-02
Effective Date:10-01-02

4.6 DEEMING

4.6.1 Deeming INTRODUCTION

Federal regulations do not allow deeming from a stepparent's or grandparent's income to a stepchild or grandchild.

This page last updated in Release Number: 02-01
Release Date: 01/01/01
Effective Date: 10/01/01

4.6.2 Stepparent

Don't count the income of a stepparent when you are determining MA eligibility of a stepchild(ren) only.

Count the net income of the legal parent with whom the child(ren) is living when you are determining the child(ren)'s financial eligibility.

4.6.2.1 Procedure

Step 1:
Determine the fiscal group (AFDC-Related Fiscal Group Unit) and apply the AFDC-Related income tests (8.1.4).

If they pass the **categorically** needy income test, certify all of the non-financially eligible members in the fiscal group. If they fail the categorically needy tests, go to Step 2.

Step 2:
If there are children-in-common, establish a fiscal group composed of them and their two parents. Deduct from the stepchild(ren)'s legal parent's net income an amount which when added to the stepchild(ren)'s net income equals the AFDC-Related categorically needy income limit appropriate for a group composed of the number of stepchildren in the household. Count all remaining net income of this fiscal group and test for regular MA eligibility.

If they fail a regular MA categorically needy test, go to Chapter 5.2 and test them for Healthy Start eligibility.

Step 3:
Determine the stepchild(ren)'s fiscal group (AFDC-Related Fiscal Group Unit). Deduct from the stepchild(ren)'s legal parent's net income and amount which when added to the net income of the spouse and child(ren)-in-common equals the AFDC-Related categorically needy income limit appropriate for a group composed of the spouse and the child(ren)-in-common. Count all the remaining net income of this fiscal group and test for regular MA eligibility.

If they fail a regular MA categorically needy test, go to Chapter 5.2 and test them for Healthy Start eligibility.

This page last updated in Release Number : 02-01
Release Date: 01/01/01
Effective Date: 10/01/01

4.6.3 Grandparent

Don't count the income and assets of the grandparent(s) when you are determining the eligibility of a grandchild(ren) only.

4.6.3.1 Procedure

When MA is requested only for the grandchild(ren) in a household where an unmarried minor and her child(ren) live with the unmarried minor's parent(s), count only net income of the minor parent and her child(ren).

If they fail a regular MA categorically needy test, go to Chapter 5.2 and test them for Healthy Start eligibility.

This page last updated in Release Number : 02-01
Release Date: 01/01/01
Effective Date: 10/01/01

4.7 DIVESTMENT

4.7.1 INTRODUCTION

Divestment can affect the eligibility of an institutionalized person . In the application process for MA, if it is determined that divestment occurred some time in the past, the applicant may be found ineligible for MA for a period of time.

The definitions and general rules found in sections 4.7.2- 4.7.5 apply to all divestments. The special situations in 4.7.6 - 4.7.13, while falling under the same definitions and general rules, require extra treatment because of their complexity.

This page last updated in Release Number : 02-01
Release Date :01-01-02
Effective Date :01-01-02

4.7.2. DEFINITIONS

4.7.2.1 Divestment

"Divestment" is the transfer of income, non-exempt assets, and homestead property (4.7.2.3.1), which belong to an institutionalized person or his/her spouse or both:

1. For less than the fair market value of the income or asset by:

    a. An institutionalized person, or

    b. His/her spouse, or

    c. A person, including a court or an administrative body, with legal authority to act in place of or on behalf of the institutionalized person or the person's spouse, or

    d. A person, including a court or an administrative body, acting at the direction or upon the request of the institutionalized person or the person's spouse. This includes relatives, friends, volunteers, and authorized representatives.

It is also divestment if a person takes an action to avoid receiving income or assets s/he is entitled to. Actions which would cause income or assets not to be received include:

1. Irrevocably waiving pension income.

2. Disclaiming an inheritance.

3. Not accepting or accessing injury settlements.

4. Diverting tort settlements into a trust or similar device.

5. Refusing to take legal action to obtain a court-ordered payment that is not being paid, such as child support or alimony.

6. Refusing to take action to claim the statutorily required portion of a deceased spouse's or parent's estate. Count the action as a divestment only if:

    a. The value of the abandoned portion is clearly identified, and

    b. There is certainty that a legal claim action will be successful.

    This includes situations in which the will of the institutionalized person's spouse precludes any inheritance for the institutionalized person. Under Wisconsin law, a person is entitled to a portion of his/her spouse's estate. If the institutionalized person does not contest his/her spouse's will in this instance, the inaction may be divestment.

4.7.2.2 Transfer

"Transfer" is the act of changing the legal title or other right of ownership to another person. Converting an asset from one form to another is not divestment. For example, buying a race horse for $12,000 and keeping the race horse is not divestment.

4.7.2.2.1 Date of Transfer

If the MA client has transferred real property , such as a homestead, the official date of transfer is the date the Quit Claim Deed was signed. It is not the date the transfer was recorded with the county Register of Deeds.

> **Example:** When Mrs. Puzo entered a nursing home and applied for MA on September 15, 1997, she indicated that she had divested her homestead to a nephew. When questioned about the date, she said it was about three years ago. The ES worker called the county Register of Deeds. She learned that the transfer was recorded on September 1, 1994. This was within the 36 month lookback period. Fearing that Mrs. Puzo might be subject to a divestment penalty, the ES worker asked when the Quit Claim Deed was signed. It was signed August 1, 1994, which was before the 36-month lookback period began. Therefore, Mrs. Puzo was not subject to a divestment penalty.

4.7.2.3 Nonexempt Assets

"Nonexempt assets" are those that are counted in SSI-related asset tests. Assets that aren't counted in these tests are called exempt assets. An available asset (4.5.1) can be either exempt or nonexempt.

4.7.2.3.1 Homestead Property

Homestead property, usually an exempt asset, is given special consideration in the MA divestment policy. Homestead divestments are permitted only under the circumstances described in 4.7.4, #7.

4.7.2.4 Institutionalized Person

See 5.8.4

4.7.2.5 Community Spouse

See 5.10.2.1.

4.7.2.6 Fair Market Value

"Fair market value" is an estimate of the prevailing price an asset would have had if it had been sold on the open market at the time it was transferred.

4.7.2.7 Divested Amount

"Divested amount" is the net market value minus the value received.

4.7.2.8 Net Market Value

"Net market value" is the fair market value at the time of the transfer minus any outstanding loans, mortgages, or other encumbrances on the property.

4.7.2.9 Value Received

"Value received" is the amount of money or value of any property or services received in return for the person's property. The value received may be in any of the following forms:

1. Cash.

2. Other assets such as accounts receivable and promissory notes (both of which must be valid and collectible to be of value), stocks, bonds, and both land contracts and life estates which are evaluated over an extended time period.

3. Discharge of a debt.

4. Prepayment of a bona fide and irrevocable contract such as a mortgage, shelter lease, loan, or prepayment of taxes.

5. Services which shall be assigned a valuation equal to the cost of purchase on the open market. Assume that services and accommodations provided to each other by family members or other relatives were free of charge, unless there exists a written contract (made prior to the date of transfer) for payment.

4.7.2.10 Unavailability

If an MA client or his/her spouse uses an asset in a way that makes it unavailable and doesn't receive FMV, treat that asset as divestment. An example is using an asset as collateral for someone else's loan.

This page last updated in Release Number : 04-03
Release Date:08-02-04
Effective Date: 08-02-04

4.7.3 LOOK BACK PERIOD

The lookback period is a period of time prior to application or entry into an institution. A divestment that has occurred in the lookback period or any time thereafter can cause the applicant or recipient to be ineligible.

The lookback period for divestments not involving trusts is 36 months. Look back 36 months from the:

1. Institutionalized person's date of application or review, or

2. MA recipient's date of entry into the institution.

The lookback period for divestments involving trusts is 60 months from the date of application, review or entry into an institution.

When you count backward, start counting with the month **before** the date of application or of entry into the institution as month 1. When determining which date to use, use the most recent date.

"Date of application" is the date the applicant or his/her representative (IMM I-A, 28.1.0) signs the application. If s/he does not sign the application, it is not a complete application and no divestment penalty can be imposed.

This page last updated in Release Number: 00-03
Release Date:05-05-01
Effective Date: 05-05-01

4.7.4 EXCEPTIONS

A divestment that occurred in the lookback period or any time after does not affect eligibility if any of the following exceptions apply:

1. The person who divested shows that the divestment wasn't made with the intent of receiving MA.

The person must present evidence that shows the specific purpose and reason for making the transfer. Verbal assurances that s/he was not trying to become financially eligible for Medicaid are not sufficient. S/he must show that s/he expected private health insurance or other resources would cover his/her institutional expenses. Take into consideration statements from physicians, insurance agents, insurance documents, and bank records that confirm the person's statements.

2. The community spouse divested assets that were part of the community spouse asset share.

   a. After the institutionalized person is determined eligible, the community spouse can divest assets that are part of the community spouse asset share (5.10.4.2). S/he can give them to anyone without affecting the eligibility of the institutionalized spouse.

> **Example 1:** When Ralph went into a nursing home and applied for MA, Edith's community spouse asset share was $42,000. After Ralph became eligible, Edith gave $30,000 of the community spouse asset share to a favorite nephew. This divestment did not affect Ralph's eligibility. Edith is allowed to divest all or any part of the community spouse asset share.

   b. If the community spouse receives assets from the eligible institutionalized spouse that were not part of the community spouse asset share, s/he cannot give them to anyone except persons listed in 4.7.4, #8. Giving them to someone other than these persons could cause the institutionalized person to become ineligible.

> **Example 2:** Ralph is an institutionalized MA recipient. He recently inherited $25,000, and immediately transferred it to Edith, his community spouse. This $25,000 is not part of the community spouse asset share. Therefore, Edith cannot transfer the money to anyone except "a child of any age of either spouse who is either blind or permanently and totally disabled or both" (4.7.4, #8). If she transfers it to anyone else, Ralph's eligibility for institutional services may be affected.

Homestead property is an exception. After the institutionalized person has become eligible, s/he can transfer the homestead to the community spouse, and the community spouse can transfer it to anyone. The community spouse's divestment of homestead property after the institutionalized person has become eligible, does not affect the institutionalized person's eligibility.

Example 3: When Ralph applied for institutional MA, he and Edith owned a home together. Homestead property is not counted as part of the community spouse asset share. After Ralph became eligible, he signed his 1/2 share of the home over to Edith. Edith can divest the part of the homestead which Ralph gave to her without affecting Ralph's eligibility

c. If the community spouse has assets that were not part of the community spouse asset share and that the eligible institutionalized spouse did not give to her, she can give them to anyone. Her divestment will not affect the institutionalized spouse's eligibility.

Example 4: After Ralph entered the nursing home and became eligible for MA, Edith inherited $12,000 from a favorite uncle. She gave it to a favorite nephew. This divestment does not affect George's eligibility because the money, even though not part of the community spouse asset share, did not come from Ralph.

Note: While these examples show that in some circumstances the community spouse's divestments don't affect the institutionalized person's eligibility, they may affect the community spouse's eligibility if s/he later enters an institution and applies for MA.

3. The ownership of the property is returned to the person in the fiscal group who originally disposed of it.

4. Division of property as part of a divorce or separation action, and loss of property due to foreclosure or repossession aren't divestment.

5. The person intended to dispose of the asset either at fair market value or other valuable consideration.

Example 5: Gary had a lucky 3-cent postage stamp that he carried in his wallet. A friend admired it, so Gary sold it to him for $0.03, unaware that it was worth more. The friend sold it to a stamp dealer for $7300. When Gary applies for MA, this divestment will be disregarded.

6. The agency determines that denial of eligibility would work undue hardship on the person. "Undue hardship" is a serious impairment to the institutionalized person's immediate health.

The ESS must verbally inform the person of this undue hardship provision if the ESS has determined the per-son has divested. The undue hardship notice must be included on all manual MA institution denials and closures due to divestment.

7. The institutionalized person or his/her spouse divests homestead property to his/her:

   a. Spouse.

   b. Child who meets at least 1 of the following conditions:
      - Under 21 years of age
      - Blind
      - Permanently & totally disabled

   c. Sibling who:

      - Was residing in the institutionalized person's home for at least 1 year immediately before the date the person became institutionalized.

        Verify that the sibling was residing in the institutionalized person's home for at least 1 year immediately before the person became institutionalized. Don't require a specific type of verification. Some examples of verification are written statements from nonrelatives, social services records, tax records, and utility bills with the address and the sibling's name on them.

        and

      - Has a verified equity interest in the home.

        "Equity interest" means an ownership interest in a homestead.

        Ask to see a copy of the deed or the land contract or some other document to verify the sibling's equity interest in the homestead. Since the sibling's name on the document is not sole proof, you may need to require other documentation such as canceled checks and receipts.

   d. A minor or adult child of the institutionalized person. The child must have

      - Been residing in the person's home for at least 2 years immediately before the person became institutionalized, and

      - Provided care to him/her which permitted him/her to reside at home rather than in the institution, or which permitted him/her to avoid becoming a community waivers participant. This care must have been provided for the entire 2 years immediately before the person became institutionalized. Get a notarized statement that the person was able to remain in his/her home because of the care provided by the child.

The statement must be from his/her physician or from someone else who has personal knowledge of his/her living circumstances. A notarized statement from the child does not satisfy these requirements.'

8. The institutionalized person or his/her community spouse divests a non-homestead asset or assets to:

    a. Spouse.

    b. A child of any age of either spouse who is either blind or permanently and totally disabled or both.

This page last updated in Release Number : 01-02
Release Date :04-01-01
Effective Date 04-01-01:

4.7.5 PENALTY PERIOD

If there was a divestment during the lookback period or any time after, and if none of the above exceptions apply, the institutionalized person must be determined ineligible for a period of time.

During this penalty period Medicaid will not pay the institutionalized person's daily care rate in the nursing home. A Community Waivers applicant or recipient is ineligible for Community Waivers. S/he may, however, still be eligible for MA card services (4.7.15)

The penalty period begins with the month of divestment and extends for the number of months that result from dividing the divested amount (4.7.2.7) by the average nursing home cost to a private pay patient ($4,827).

Round all fractions downward. For example, 8.6 = 8 months, .7 = 0 months.

Example 1: Jeff transfers $80,816 in cash, CDs, and stocks to The Green Tree Brethren, Inc. $80,816 divided by $4,827 is 16.74. Jeff is ineligible for 16 months.

To shorten a divestment penalty period when some of the originally divested amount is returned, subtract the divestment amount returned from the original divestment amount. Then divide the divestment remainder by the original average nursing home pay rate that was used to calculate the original divestment penalty period. To determine the new divestment penalty period, drop the fraction, use whole months, and begin the new shortened penalty period in the month the divestment occurred.

Send the client a notice advising him/her that the consequence of the partial divestment payback is a reduced penalty period and specify the new penalty dates.

Example 2: Jeff transfers $80,000 in cash to his family in January. The penalty period is 16. months. But in March he returns $50,000 of the divestment. To determine the shortened divestment penalty period, $80,000 minus $50,000 is $30,000. $30,000 divided by $4,827 is 6.215. The worker sends Jeff a notice that says that the shortened penalty period is six months, beginning in January.

If another divestment occurs when a penalty period is in effect, another penalty must be calculated for the most recent divestment. This calculation would use the divestment penalty divisor currently effective. The whole month penalty period that is derived from this most recent divestment determination is added onto the previous penalty, but the new penalty period will not begin until the existing period has expired. The penalty periods cannot run concurrently.

Send the client a notice advising him/her that the consequence of the new divestment is an increased penalty period and specify the new penalty dates.

Example 3: In June, Jeff in Example 1, transfers another $40,000 to friends. $40,000 divided by $4,827 is 8.27. The divestment penalty period is 8 months. The new divestment period of eight months begins in July, the month after the original divestment penalty period has ended. The new divestment penalty period does not run concurrently with the original divestment period.

The divestment report, CRM1403A, doesn’t register divestment penalty changes. If it is necessary to remove a divestment penalty, update AAAT, run SFED, and confirm. Then contact EDS (608-221-4746, ext. 3103). Provide EDS with the date that the divestment penalty was removed. The level of care will then be revised. Also contact the appropriate individual at the client’s nursing home to submit bills for the period that is now covered by institutional MA.

Reminder: the divestment notices are inaccurate. Send a manual notice explaining eligibility for card services, the reason for service reduction, and the number of months in the penalty period when a case receives a divestment penalty. Include the legal citation [49.453 Wis. Stats.].

4.7.6 MULTIPLE DIVESTMENTS

Multiple divestments are two or more separate divestments made within a 36-month period before the MA application date or the date of entering an institution or at any time thereafter.

For multiple divestments:

1. Add together all the divested amounts of transfers in the lookback period or any time thereafter that are connected in any of the following ways:

    a. Transfers that occur in the same month.

    b. Transfers that occur in both months of a period of any two consecutive months.

    c. Transfers with a penalty period (4.7.5) that extends into a month in which there is another transfer.

    d. Transfers with a penalty period (4.7.5) that extends into the month immediately preceding a month in which there is another transfer.

2. Calculate the penalty period (4.7.5).

> **Example:** Ernie enters a nursing home and applies for MA in July 1994. In the 36-month look-back period he made the following transfers:
>
> 11-1-93 $20,000 cash to a friend
> 4-1-94 $5,000 bond to grandson
> 5-1-94 $5,000 bond to grandson
> 6-1-94 $5,000 bond to grandson
> 7-1-94 $5,000 bond to grandson
>
> The 11-1-93 transfer has a penalty period of five months. Since it goes to 3-31-94, it extends into the month that immediately precedes the month of another transfer, the 4-1-94 transfer. Each of the later transfers, the 4-1-94, 5-1-94, and 6-1-94, occur in consecutive months. Therefore, add together all of the divested amounts from 11-1-93 through 7-1-94 to calculate the penalty period.

If there are transfers in the lookback period which are not connected in any of the ways described above, treat them as separate and calculate a separate penalty period (4.7.5) for each.

This page last updated in Release Number : 03-02
Release Date : 04-01-03
Effective Date : 04-01-03

4.7.7 JOINTLY HELD ASSETS

When an institutionalized person owns an asset in common with another person and when s/he or the other person or any person acting on their behalf transfers the asset during the lookback period or anytime thereafter, s/he may be penalized for divestment if the transfer:

1. Reduces or eliminates the institutionalized person's ownership or control of the asset, or
2. Limits the institutionalized person's right to sell or otherwise dispose of the asset.

"Holding an asset in common" means holding it through joint tenancy, tenancy in common, joint ownership, or partnership.

Example 1: For many years Debra held a joint account with her daughter, Donna. On October 15, 1996, Donna withdraws $13,000 from it. On December 3, 1996, Debra enters a nursing home and applies for MA. The $13,000 withdrawal is a divestment. A penalty period must be calculated and imposed.

If placing another individual’s name on the account, or asset actually limits the individual’s right to sell or otherwise dispose of the asset, such placement would constitute a transfer of assets. For example, the addition of another individual’s name requires that the other individual agree to the sale or the disposal of the asset, where no such agreement was necessary before.

Example 2: John bought a piece of property with his nephew, Carl. Three months later John requested to participate in the community waivers program. John explained that his nephew, Carl, refused to sell the property and, therefore, it was unavailable and should not be counted as an asset. The ESS agreed with John that the land wasn't available and wouldn't be counted as an asset. But, the purchase of the property and the nephew’s refusal to make it available (through liquidation) to meet John's needs was divestment. Therefore, John is subject to a penalty period starting from the 1st of the month in which the jointly owned property was purchased.

When a person's name appears as co-owner of a jointly held asset, assume s/he is part owner of the property. However, you must inform him/her that s/he has a right to present evidence showing she is not an owner (4.5.3).

This page last updated in Release Number : 03-03
Release Date:09-22-03
Effective Date: 09/22/03

4.7.8 DIVESTING BY PAYING RELATIVES

It is divestment when an institutionalized person transfers resources to a relative in payment for care or services the relative provided to him/her. A relative is anyone related to the institutionalized person by blood, marriage, or adoption.

Count all the payments for care and services which the institutionalized person made to the relative in the last 36 months. The form of payment includes cash, property, or anything of value transferred to the relative. It is not divestment if all of the following conditions exist

1. The services directly benefited the institutionalized person.

2. The payment did not exceed reasonable compensation for the services provided.

   "Reasonable compensation" is the prevailing local market rate for the service at the time the service is provided.

> **Example 1:** Ms. Rain applies for community waivers on 1-10-95. She paid her son $3,500 to remodel her bathroom the previous month. She shows that her son installed new tile and fixtures. You check with a local contractor who estimates the he would charge $4,000 for the same job. Since Ms. Rain received FMV, it’s not divestment.

> **Example 2**:. Ms. M enters a nursing home on 12-12-95 and applies for MA. She reports she paid her daughter $7,000 in December for coming to her house each evening and fixing dinner for the previous 2 months. You check with a local agency that provides meals to homebound persons. They charge $2 for each meal. Ms. M's daughter provided 61 meals. The fair market value of the meals was $122. You determine Ms. M overpaid her daughter. The divested amount is $6,878 ($7000-$122).

3. If the amount of total payment exceeds 10% of the community spouse asset share (5.10.4.2), the institutionalized person must have a written, notarized agreement with the relative. The agreement must:

   a. Specify the service and the amount to be paid, and

   b. Exist at the time the service is provided.

Example 3: Ms. A enters a nursing home and applies for MA on 11-1-96. When asked if she has transferred any assets in the past 36 months, she reveals that she has. She paid her daughter $10,000 in exchange for personal care which her daughter had provided to her the past 2 years. This $10,000 payment would ordinarily be counted as a divestment, since it is above 10% of Ms. A's community spouse asset share.

But she shows you a written, notarized statement, dated 10-09-94, in which she promises to pay $10,000 to her daughter for the specified care. Therefore, there is no divestment.

If there is no community spouse, use 10% of the highest possible CSAS in 5.10.4.2.

4.7.8.1 Room & Board

If an institutionalized person has made room & board payments to a relative, disregard them if:

1. The payments do not exceed fair market value of the room & board, and

2. Are for periods when the institutionalized person was receiving the room & board.

If the room & board is paid after the person has been institutionalized, treat the payment as divestment unless:

1. The payment is only for the month immediately preceding the month s/he entered the institution, or

2. S/he provides a written lease that existed during the time s/he was receiving room & board from the relative.

This page last updated in Release Number : 01-01
Release Date : 01-01-01
Effective Date : 01-01-01

4.7.9 INCOME DIVESTMENT

Income received by an institutionalized person and transferred in the month of receipt is considered divestment.

Example 1: Mr. M. resides in a nursing home. He receives a pension check of $3,000 a month. Mr. M. immediately signs the check over to his son. This is a divestment.

Unless there is reason to believe otherwise, assume that ordinary household income was legitimately spent on the normal costs of living.

However, there may be divestment if the person transferred amounts of regularly scheduled income which s/he ordinarily would have received. Such a transfer usually takes the form of a transfer of the right to receive income.

When you find the institutionalized person has transferred income or the right to receive income, calculate a penalty period based on the total amount of income transferred.

Example 2: Donald transfers his rights to his $325,000 pension to his daughter. The divested amount is $325,000, not the $4,500 the daughter expects to receive each month from the pension.

This page last updated in Release Number: 02 01
Release Date:01-01-02
Effective Date:01-01-02

4.7.10 LIFE ESTATES

When a person conveys a life estate (4.5.8.1.5) to himself/ herself and designates a remainder person (4.5.8.1.5), the amount of remainder interest is considered an asset transfer. If the transfer was for less than fair market value, treat it as a divestment.

Example 1: Mrs. W., age 82, conveys her home into a life estate. She holds the life estate, and the remainder person is her son. Within 36 months she enters a nursing home and applies for MA. The home's fair market value was $67,500. Mrs. W. received no payment from her son, the remainder person. The divested amount is $40,300.86 ($67,500 x .59705).

It is also divestment if the life estate holder transfers the life estate interest for less than fair market value.

Example 2: Jim conveyed his home into a life estate 12 years ago. Now he wants to enter an institution and get MA. So he gives the life estate to his friend Barney, the remainder person, and receives no compensation in return. This is a divestment. What is the divested amount? The home's fair market value is $125,000. Jim is age 75 at the time of the divestment. The divested amount is $65,186 ($125,000 x .52149).

4.7.10.1 Jointly Owned

To determine the value of an individual's share of a jointly owned life estate which was divested:

1. Divide the home's fair market value (FMV) by the number of owners.

2. Go to chapter 8.1.02 and get the life estate figure which corresponds with each person's age.

3. Multiply the life estate figure for each person by their share of the FMV.

4. Add the results together for each person who divested.

Use the value of the home and age of the person when the home was sold or given away.

> **Example 1:** A husband and wife give away their life estate. The home's FMV is $50,000. He is 73. She is 67. Half of $50,000 is $25,000.
> (73) .55571 x $25,000= $13,892.75
> (67) .65098 x $25,000= + <u>$16,274.50</u>
> $30,167.25
> $30,167.25 is the value of the life estate.

This page last updated in Release Number : 02-01
Release Date :01-01-02
Effective Date : 01-01-02

4.7.11 ANNUITIES

It is divestment if an institutionalized person transfers assets or income to an annuity (4.5.7.4) when any of the following conditions exist:

1. S/he chooses a settlement option that has a pay-out schedule extending beyond his/her life expectancy.

   The divested amount is the total of all payments scheduled after the month in which the person's age exceeds his/her life expectancy.

   Determine the person's life expectancy as follows:

a. Find his/her age on the date s/he chose the settlement option.

b. Consult 8.1.10 for his/her life expectancy.

Example: A 76-year-old man purchases an annuity and chooses a settlement option on January 1, 1994. The annuity will make $100 payments to him beginning January 1, 1994 and ending December 31, 2010. His life expectancy is age 86. He will turn 87 on December 1, 2004. Total the payments from January 1, 2005 through December 31, 2010. The total is the divested amount.

The life expectancy value can be adjusted based on a medical condition diagnosed by a physician before the person transferred funds to the annuity or trust.

2. S/he purchases an annuity that has no cash or surrender value, and s/he does not choose a settlement option.

   The divested amount is the amount the institutionalized person paid for the annuity. (If there is a cash or surrender value, count it as an available asset.)

3. S/he purchases an annuity in which neither s/he nor his/her spouse nor a blind or permanently disabled child of any age of either spouse is named the annuitant.

4. S/he purchases an annuity in which there are not fixed, periodic payments made within his/her life expectancy.

This page last updated in Release Number : 02-01
Release Date :01-01-02
Effective Date :01-01-02

4.7.12 PROMISSORY NOTES

It is divestment if an institutionalized person signs a promissory note that has one of the following:

1. A provision that forgives a portion of the principal.
2. A balloon payment.
3. Interest payments only, with no principal payments.
4. An inadequate interest rate (relative to current market rates) at the time the promissory note was signed.

This page last updated in Release Number: 02-01
Release Date:01-01-02
Effective Date:01-01-02

4.7.13 TRUSTS

"Trust" is any arrangement in which a person (the "grantor") transfers property to another person with the intention that person (the "trustee") hold, manage, or administer the property for the benefit of the grantor or of someone designated by the grantor (the "beneficiary"). The term “trust” includes any legal instrument or device that is similar to a trust.

"Legal instrument or device similar to a trust" means any legal instrument, device, or arrangement which, even though not called a trust under state law, has the same attributes as a trust. That is, the grantor transfers property to the trustee and the grantor's intention is that the trustee hold, manage, or administer the property for the benefit of the grantor or of the beneficiary. For purposes of this section, an individual shall be considered to have established a trust if assets of the individual are used to form all or part of the corpus (principal) of the trust.

"Grantor" may be:

1. The MA client.

2. His/her spouse.

3. A person, including a court or an administrative body, with legal authority to act in place of or on behalf of the client or his/her spouse. This includes a power of attorney or a guardian.

4. A person, including a court or an administrative body, acting at the direction or upon the request of the client or his/her spouse. This includes relatives, friends, volunteers or authorized representatives.

4.7.13.1 Revocable Trusts

A revocable trust is a trust that can be revoked, canceled or modified by the grantor or by a court. A trust which is called irrevocable, but which will terminate if some action is taken by the grantor, is considered a revocable trust.

1. The trust principal of a revocable trust is an available asset. “Trust principal” is the amount placed in trust by the grantor plus any trust earnings paid into the trust and left to accumulate.

2. All payments from the trust to or for the benefit of the institutionalized person are income.

3. All payments from the trust that are not to or for the benefit of the institutionalized person are divestment.

4.7.13.2 Irrevocable Trusts

An irrevocable trust is a trust that cannot, in any way, be revoked by the grantor.

The following actions are divestment if they took place during the lookback period or any time after:

1. An irrevocable trust was created. The **divested amount** is the total amount of the created trust.

   Sometimes revocable trusts contain a clause that causes them to become irrevocable at a later date in the life of the trust. Divestment occurs on the date the trust changed from revocable to irrevocable.

> **Example:** In 1988 Benny created a revocable trust fund of $100,000 for his daughter. There was a clause in the trust stating the trust would become irrevocable if Benny became incompetent. He was determined incompetent on February 2, 1997, and the trust changed from revocable to irrevocable. Benny entered an institution and applied for MA in July, 1998. He divested the total amount of the trust on February 2, 1997.

2. Funds were added to the irrevocable trust. The **divested amount** is the amount of the added funds.

If either of these actions took place before the **lookback period,** apply the following rules:

1. Payments to the institutionalized person from trust income or from the body of the trust are income.

2. Payments that could be disbursed to the institutionalized person from trust income or from any portion of the body of the trust but that are not disbursed are available assets.

3. Payments from the trust to anyone other than the institutionalized person are divestment.

4.7.13.3 Exceptions

The policies described in this trusts section do not apply to any of the following trusts.

1. Annuities (4.7.11).

2. Irrevocable burial trusts (4.5.5.1).

3. Trusts established by a will.

4. Special Needs Trusts - A trust containing assets of an individual under age 65 who is totally and permanently disabled (under SSI program rules)Disregard the trust if it meets these conditions.

    a. The trust must be established for the sole benefit of the disabled person by his/her parent, grandparent, legal guardian or a court, and

    b. Contain a provision that, upon the death of the beneficiary, the Wisconsin MA program will receive all amounts remaining in the trust not in excess of the total amount of MA paid on behalf of the beneficiary.

   The exception continues after the person turns 65, provided s/he continues to be disabled. However, a grantor cannot add to the trust after the beneficiary turns 65. Anything added to the trust after the beneficiary turns 65 is a divestment. Money added before the beneficiary turns 65 is not a divestment.

5. Pooled trusts. These are trusts for disabled persons as determined by SSI rules. Disregard them if they meet the following conditions:

    a. Established and managed by a non-profit association.

    b. A separate account is maintained for each beneficiary. For purposes of investment and management, the funds from separate accounts may be pooled together.

    c. The trust must be established for the sole benefit of the disabled person by his/her parent, grandparent, legal guardian or a court.

    d. Contain a provision stating that upon the death of the beneficiary the trust will use the funds remaining in the account to reimburse Wisconsin's MA program.

This page last updated in Release Number : 03-03
Release Date :09-22-03
Effective Date :09-22-03

4.7.14 BOTH SPOUSES INSTITUTIONALIZED

If the community spouse made a divestment that resulted in a penalty period for the institutionalized spouse (see 4.7.4 2b), apportion the penalty period between the spouses at the time the community spouse enters an institution and applies for MA.

Example: Joe Penner is in a nursing home. Mrs. Penner is his community spouse. Joe inherited $84,000 and immediately transferred it to Mrs. Penner. This $84,000 was not part of the community spouse asset share. Mrs. Penner gave it to her church. This divestment resulted in a penalty period of 26 months for Joe Penner. Now Mrs. Penner is entering the nursing home and applying for MA. The time that remains on Joe Penner's penalty period must be apportioned to both spouses.

Apportion the penalty period as follows:

1. Find the divested amount that was used to calculate the original penalty period.

2. Calculate how much of the divested amount remains to be satisfied by:

   a. Multiplying the average nursing home private pay rate x the number of complete months of the penalty period already served, and

   b. Subtracting the result from the original divested amount.

3. Calculate the penalty period for the remaining divested amount.

4. Divide the new penalty period equally between the 2 spouses.

If either spouse leaves the institution or dies, add the remainder of his/her penalty period to the other spouse's penalty period.

This page last updated in Release Number : 01-05
Release Date : 10-01-01
Effective Date :10-01-01

4.7.15 MA CARD SERVICES

MA card services are all the MA covered services (7.1.1) except SNF/ICF payments and ancillary services (Wis. Ad. Code 107.09(2) and (4)(a). These excepted services consist of the routine, day-to-day health care services that are provided to MA recipients by a nursing home and that are reimbursed within the daily care rate.

4.7.15.1 Nursing Home

A person who, because of divestment, isn't eligible for services reimbursed within the daily institutional care rate is still eligible for MA card services.

4.7.15.2 Community Waivers

Community waivers (CW) clients who have divested cannot receive CW benefits and can't use CW eligibility criteria. They may be eligible for MA card services. Determine eligibility using regular MA methodology.

Send a notice to the CW case manager telling him/her of the client's ineligibility for waiver services.

This page last updated in Release Number : 01-05
Release Date : 10-01-01
Effective Date :10-01-01

4.7.16 GAMBLING

Gambling losses at a casino, racetrack or in some other type of regulated gambling is not divestment. It is divestment if the client makes personal bets with friends or relatives or has losses from unregulated gambling.

This page last updated in Release Number: 01-05
Release Date: 10-01-01
Effective Date:10-01-01

FFU and Deductibles

4.8 FAMILY FISCAL UNIT (FFU)

4.8.1 DEFINITION

Family Fiscal Unit (FFU) is individual financial eligibility testing for Family Medicaid.

Only perform this financial test if a non-financially eligible person:

1. Fails Family MA fiscal test group (FTG) solely for income, and

2. The fiscal test group contains a:

    a. Pregnant woman.
    b. Child with income.
    c. Stepparent.
    d. Non-Marital Co-Parent (NMCP).
    e. Non-legally responsible (NLRR) child.

This page last updated in Release Number: 02-03
Release Date: 07-01-02
Effective Date: 07-01-02

4.8.2 OVERVIEW

Test members of the group using the Family MA FTG (5.1.5) process before testing them individually through FFU.

Some members of the household may be determined eligible for MA through the FTG process. These clients do not need to be tested using the FFU process, and will remain eligible for MA under the FTG policy regardless of the outcome of any FFU testing done for others.

This page last updated in Release Number: 02-03
Release Date: 07/01/02
Effective Date: 07/01/02

4.8.3 PROCESS

Follow these steps when determining FFU eligibility. See the FFU Income Worksheet (WKST 13).

1. Gather income information for each member of the AG, and apply the appropriate disregards.

2. Prorate each person's income by the number of people each person is legally responsible for (including themselves).

3. Allocate the prorated income amount to each person that the target person has legal responsibility for (including themselves)

4. Add up the total income of the person including the prorated share of his/her own income and the income allocated to him/her from persons legally responsible for him/her. This is the income test amount.

5. Determine the FFU size. Exclude SSI recipients when determining group size. You may allocate to the SSI recipient, but you cannot allocate from the SSI recipient.

   Determine FFU size based on legal responsibility. Include the person you are testing and anyone who is legally responsible for him/her. Increase a pregnant woman's FFU size by the number of fetuses she is carrying. The fetuses only increase the FFU size of the pregnant woman and not anyone else in the household. Test each person individually. This may result in different FFU sizes for each FFU test.

   To make the manual process of determining eligibility based on Family Fiscal Unit easier, we use the term "FFU size" in 4.8.4 to mean the person you are testing and all those who are legally responsible for that person, without including the fetuses. Follow the FFU size across to the columns on the left to include the fetuses. For example, the income limit for a pregnant mom (one fetus) with one child would be found by looking under the row for FFU size one, and then moving over to the column for "number of fetuses" equal to one.

Example 1: Mom has two children, Molly and Mindy. Mindy has income of her own. The case failed Healthy Start fiscal group testing so is in FFU. Mom's FFU size is one since she is legally responsible for herself, no one is legally responsible for her, and she is not pregnant. Mindy's group size is two (herself and mom, who is legally responsible for her), and Molly's group size is also two.

Mom remarries. Now, mom's group size is two, herself and her husband. The children's group size remains the same. The step-dad's group size is two. He is only legally responsible for his wife and himself.

6. Compare the income test amount to the first appropriate individual income limit (4.8.4) that corresponds to his/her FFU size (from top to bottom). If the person's test amount is equal to or less than his/her income limit, s/he is eligible for that category if all non-financial requirements are met for that

category.

If the client you are testing is pregnant, follow the row with her FFU size across until it meets the column with the number of fetuses she is carrying.

Example 2 : Helen is pregnant with twins. She is 17 years old and lives with her mom.

1. Her FFU size is four (Helen, her mom, and two fetuses). In 4.8.4, the FFU size would be two with two fetuses.

The Healthy Start cat needy income limit for FFU size four (in 4.8.4, FFU size of two and read across the chart to the number of fetuses (two) is $1,566.91.

Caretakers are not eligible if they fail categorically needy income tests. Do not test them for medically needy.

7. If s/he fails at this income level, continue to test his/her income against the next appropriate income limits that corresponds to his/her FFU size.

8. Determine a deductible (4.9), if s/he fails all appropriate categories of MA.

This page last updated in Release Number : 04-01
Release Date: 02/27/04
Effective Date: 02/27/04

4.8.4 INCOME LIMITS

			Number of Fetuses					
	MA Category	FFU Size	0	1	2	3	4	5
MAU/MAR	AFDC		**	**	**	**	**	**
MAOU/MAOR	AFDC-Related MA (cat needy) area 1	1	$311	$550.00	$647.00	$772.00	$886.00	$958.00
		2	$275.00	$431.33	$579.00	$708.80	$798.33	$888.86
		3	$215.67	$386.00	$531.60	$638.67	$740.71	$824.25
MAOU/MA	AFDC-Related MA Area 2 (cat needy)	1	$301.00	$533.00	$626.00	$749.00	$861.00	$929.00

		2	$266.50	$417.33	$561.75	$688.80	$774.17	$863.14
		3	$208.67	$374.50	$516.60	$619.33	$719.29	$801.00
NAOR	AFDC-Related MA (med needy)	1	$591.67	$591.67	$689.33	$822.67	$944.00	$1,021.33
		2	$295.84	$459.55	$617.00	$755.20	$851.11	$947.43
		3	$229.78	$411.34	$566.40	$680.89	$789.52	$879.00
MHSN	Healthy Start children age 6-19	1	$775.83	***	***	***	***	***
		2	$520.42	***	***	***	***	***
		3	$435.28	***	***	***	***	***
MHSC/MHSP	Healthy Start Pregnant Women & Children < 6 (med needy)	1	$1031.86	$1,384.31	$1,736.76	$2,089.21	$2,441.66	$2,794.11
		2	$692.15	$1,157.84	$1566.91	$1,953.33	$2,328.42	$2697.05
		3	$578.92	$1044.60	$1,465.00	$1862.74	$2,247.54	$2,624.26
NHSC/NHSP	Healthy Start Pregnant Women & Children < 6 (med Needy)	1	$1,435.29	$1,925.54	$2,415.79	$2,906.04	$3,396.29	$3,886.54
		2	$962.77	$1,610.53	$2,179.53	$2,717.03	$3,238.78	$3,751.53
		3	$805.26	$1,453.02	$2,037.78	$2,591.03	$3,126.28	$3,650.28

** FFU is not used in determining eligibility for AFDC-Medicaid .

*** Pregnant women are not eligible for this category. Determine pregnant women under the age of 19 for Health Start for Women instead.

This page last updated in Release Number: 04-03
Release Date: 08-02-04
Effective Date: 03-01-04

4.9 DEDUCTIBLE

4.9.1 introduction

When a MA applicant is ineligible for MA solely because s/he has income that exceeds the MA medically needy income limit, s/he can become eligible by meeting the MA deductible (4.9.2). "Meeting the MA deductible" means incurring medical costs that equal the dollar amount of the deductible.

This page last updated in Release Number: 97-03
Release Date: 07-01-97
Effective Date: 07/01/97

4.9.2 MA Deductible

The MA deductible is the group's (fiscal or FFU) total excess monthly income over the 6 consecutive months of the MA deductible period (4.9.3).

"Excess monthly income" is the amount which is above the group's (fiscal or FFU) monthly medically needy income limit.

This page last updated in Release Number: 97-03
Release Date: 07-01-97
Effective Date: 07/01/97

4.9.3 Deductible Period

The MA deductible period is a period of 6 consecutive months. It is the length of time the group (fiscal or FFU) has for meeting the MA deductible. It begins in the month which the applicant chooses, and it ends 6 months later.

The applicant can choose to begin the MA deductible period as early as 3 months prior to the month of application, and as late as the month of application.

Example 1: John applies for MA in July. He can choose to begin his 6 month MA deductible period in April, May, June, or July.

The applicant cannot choose an MA deductible period which includes a month in which, if s/he had applied, s/he would have been ineligible for some reason other than excess income.

Example 2: Doyle applies for MA in July. He has excess income in July. He wants an MA deductible period that goes from April through September. In addition to having excess income in April, Doyle had $5,000 in his savings account on April 30. He cannot include April in his MA deductible period. He no longer had the $5,000 on May 31, so he can begin his MA deductible period in May.

Example 3: Clarice applies for MA in July. She has excess income in July. She wants an MA deductible period that goes from April through September.

In addition to having excess income in April and May, Clarice had an inheritance of $5,000 in May. She still retained it on May 31. Therefore, she cannot include May or **any months prior to May** in her MA deductible period. She no longer had the $5,000 on June 30, so she can begin her MA deductible period in June.

Example 4: Marion applies for MA in July. She has excess income in July. She wants an MA deductible period that goes from April through September.

In addition to having excess income in April, May, and June, Marion had sold her car for $5,000 and still retained the money on June 30. She cannot include June or **any months prior to June** in her MA deductible period. She no longer has the $5,000 on the date of her July application, so she can begin her MA deductible period in July.

Example 5: Bobby Lee applies for MA in July. He has excess income. He also has $5,000 in his checking account at the time of application. He is ineligible. He cannot have an MA deductible period that begins in July or in **any months prior to July**.

For backdate months, when a person had excess assets in any of the 3 months prior to the month of application, his/her eligibility in the backdate month is determined by whether or not s/he had excess assets **on the last day of the month.**

Example 6: Jack applies for MA in July. He wants an MA deductible period that goes back 2 months to include May and June. In May, he would have been eligible except for excess income. In June he had received a $10,000 gift. On June 29 he went to the track and lost the $10,000. Had he applied on June 30 he would have been eligible. Jack can include both May and June in his MA deductible period.

Example 7: Mansour applies for MA in July. He is found to be eligible. He had medical bills in April and May. He also had excess income in April and May. He wants an MA deductible period that includes April and May. Unfortunately, he was the recipient of a $5,000 cash gift on June 29. It was several days before he was able to spend it on groceries and other legitimate purchases. Mansour will not be able to include April or May in the deductible period because on June 30, had he applied, he would have been determined ineligible.

An individual can establish a new deductible period at any time if they file an application for Medicaid. This includes situations where someone has already established a deductible period, hasn't yet met the deductible, and wishes to establish a new deductible period. This will usually occur as a result of a recent decrease in their monthly income.

Example 8: Jeff applies for Medicaid on 1/1/04 and his monthly excess income is \$100.00. His Medicaid deductible is \$600.00 and his deductible period is January 01, 2004 through June 30, 2004. In April 2004, Jeff's monthly excess income decreases to \$10.00 a month. Jeff reports the decreased income in April and now has a choice between 2 different deductible recalculations. He can either have his worker recalculate the original \$600.00 deductible which would then become a \$330.00 deductible (3 months of \$100.00 excess income and 3 months of \$10.00 excess income) or since he hasn't yet met that deductible, he can file a new application in April and establish a new deductible period of April 2004 through September 30, 2004 with a \$60.00 deductible obligation (\$10.00 x 6 = \$60.00). If Jeff hasn't already incurred any substantial medical expenses, he may want to file a new application, set a new deductible period, and be in a better position to meet a much smaller deductible. (4.9.7.1)

Individuals who have been certified for Medicaid after meeting a deductible, will automatically have a new deductible period established. The new deductible period begins the first day of the first month after the previous Medicaid deductible certification ended. Similarly, Medicaid recipients, who do not meet a deductible within a deductible period automatically have a new deductible period established beginning the first day of the first month after their original deductible period ended. CARES does not send a review notice to the client regarding the new deductible period if s/he did not meet the deductible for the current period.

This page last updated in Release Number: 05-01
Release Date: 01/11/05
Effective Date: 01/11/05

4.9.4 Choosing Not to Have a Deductible

An applicant who is ineligible for excess income in some backdate months, but has no excess income in others, does not have to choose to have an MA deductible. S/he can choose to be certified in the months s/he is eligible and to accept the ineligibility of the other months where s/he has excess income.

Example 1: Horace applies for MA in July. He has no income and does not expect any income in the future. He is financially eligible in July. He also wants MA eligibility for April to cover some medical expenses he had in April. In April he would have been eligible because he had no income or assets. But in May and June he had **excess** income of \$20 each month. He has 2 choices: Choose an MA deductible period of April through September. After meeting the

MA deductible of $40 he would be certified for MA from April through September.

Not choose an MA deductible period. He would not have to meet an MA deductible. He could be certified immediately for April and July. But he would have to forego MA for May and June because of the excess income in May and June.

If the applicant has excess income in the month of application, but no excess income in the 3 months prior to the month of application, s/he does not have to include them in a deductible period. S/he can be certified for them immediately, and can begin the MA deductible period with the month of application.

Example 2: Roslyn applies for MA in July. She is ineligible because she has excess income. She had no income in April, May, or June. She can be certified immediately for April, May, and June. She begins her MA deductible period in July.

This page last updated in Release Number: 97-03
Release Date: 07-01-97
Effective Date: 07/01/97

4.9.5 Calculating the MA Deductible

To calculate the dollar amount of the MA deductible for a regular MA fiscal test group:

4.9.5.1 Fiscal Test Groups

1. Determine the MA deductible period (4.9.3) for this fiscal test group.
2. Find the fiscal test group's total net income for each month in the deductible period.

   For the months after the month of application, use prospective net income. (Income that may have been disregarded in the eligibility test which must now be counted, add back in, when determining the deductible period) (5.11.4).

3. Compare the total net income of each month with the group's medically needy income limit. If the group is an:

   a. AFDC-related fiscal test group, see 8.1.4

   b. SSI-related fiscal test group, see 8.1.5.

   If a month's income is less than or equal to the medically needy limit, ignore it.

   If a month's income is more than the medically needy limit, find the excess income by subtracting the income limit from the net in-come of that month.

4. Add together the excess income of the months in the deductible period. The result is the MA deductible.

4.9.5.2 Individuals

4.9.5.2.1 Non-Healthy Start

To calculate the MA deductible for non-Healthy Start persons who were tested individually and who failed the FFU Income Test:

1. Find all the members of this person's FFU. If you do not know how to determine who is in this person's FFU, consult 4.8.

2. From the members of this FFU form a group that includes all Family MA related persons who are eligible or would be eligible except for excess income. But do not include any:

    a. Pregnant Women.
    b. Children under age 6.
    c. Caretakers (3.5.2) who failed the individual categorically needy income test.

3. Determine the MA deductible period (4.9.3) for this person.

4. Find the monthly excess income of each of the persons in the group you formed in #2. Do this by subtracting each person's individual medically needy income limit from his/her income test amount (FFU Income Worksheet).

5. Add the monthly excess incomes of these persons together.

6. The total is this person's MA deductible.

4.9.5.2.2 Healthy Start

To calculate the MA deductible for Healthy Start persons who were tested individually and who failed the FFU income test for Healthy Start:

1. Find all the members of this person's FFU. If you do not know how to determine who is in this person's FFU, consult 4.8

2. From the members of this FFU form a group that includes all Family MA related persons who are eligible or would be eligible except for excess income. But do not include any:

    a. Children age 6 or over.
    b. Non-pregnant caretakers.

   c. Stepparents.
   d. Nonmarital co-parents.

3. Determine the MA deductible period (4.9.3) for this person.

4. Find the monthly excess income of each of the persons in the group you formed in #2. Do this by subtracting each person's individual medically needy income limit (8.1.6) from his/her income test amount (FFU Income Worksheet).

5. Add the monthly excess incomes of these persons together.

6. The total is this person's MA deductible.

4.9.5.3 Institution Cases

4.9.5.3.1 Backdating

Institutionalized and non-institutionalized persons can be eligible back to the 1st of the month, 3 months prior to the month of application. Even if they are ineligible in the month of application, they may still be eligible for retroactive coverage. When an institutionalized person requests retroactive MA, test him/her against the nonfinancial and financial standards that are appropriate to the month being tested. For the months s/he was not institutionalized, use the EBD asset and income limits (8.1.5). For the months s/he was institutionalized, use the institutional eligibility criteria found in 5.8.

4.9.5.3.2 Deductible

For the months in which s/he was not institutionalized, s/he may be eligible in some, but ineligible in others, due to excess income. In this situation, s/he has 2 choices:

1. To be certified for the months s/he is eligible, and accept the ineligibility of the other months in which s/he has excess income, or

2. To meet a deductible. The deductible period begins in the backdate month that s/he chooses, and extends 6 months. Calculate the deductible for the full 6-month deductible period. Calculate the deductible by comparing his/her monthly income for each of the 6 months to the EBD medically needy income limit, not the institutional income limit.

   Expenses which can be counted against the deductible are those listed in 4.9.8.1 **plus** his/her cost of care (5.8.7). Expenses that cannot be counted are listed in 4.9.8.2.

   When s/he meets the deductible, she can be certified to the end of the deductible period. At the end of the deductible period, redetermine his/her eligibility using the institutional financial tests.

4.9.5.4 Deductible Choice

When a fiscal test group has a deductible and individual members have an FFU deductible, the client may choose which deductible s/he wants for each individual.

This page last updated in Release Number: 02-01
Release Date:01-01-02
Effective Date:01-01-02

4.9.6 Deductible Examples

See the following deductible examples:

Example 1: Artie Cobb applies for MA in July. He wants to backdate his MA three months. His MA deductible period is April through September. In April, May, June, and July his AG had excess income of $50 each month. Its prospective excess income for August and September is $50 each month. 6 X $50 = $300. Artie's MA deductible is $300.

Example 2: Clarice applies for MA in July. She wants to backdate her MA to May 1. Her MA deductible period is May 1 through October 31. In May and June her AG had excess income of $100 each month. In July it has excess income of $200. Its prospective excess income for August, September, and October is $200 a month. Clarice's MA deductible is $1,000.

Example 3: Myron applies for MA in July. He wants to backdate MA to June 1. His MA deductible period is June 1 through November 30. In June his AG had excess income of $50. In July it has no excess income. Its prospective excess income for August, September, October, and November is $0. Myron's MA deductible is $50.

Example 4: Tillerman Tyler applies for MA in July. He wants his MA to begin July 1. His MA deductible period is July 1 through December 31. In July his AG has $100 excess income. Its prospective excess income for Au-gust, September, October, November, and December is $100 each month. Tilly's MA deductible is $600.

This page last updated in Release Number: 02-01
Release Date: 01-01-02
Effective Date:01-01-02

4.9.7 Changes During the Deductible Period

If there are income changes during the MA deductible period, recalculate the MA deductible amount.

4.9.7.1 Income Changes

1. Add together the monthly excess income of the months of the MA deductible period that have already gone by.

2. Subtract the medically needy income limit from the new monthly income. This will give the excess income for the month when the income changed.

3. Using prospective net income, find the excess income of the months in the deductible period after the month when income changed.

4. Add the results of #1, #2, and #3.

Example 1: Cicely applied for MA in July. She had excess income of $20 a month. Her MA deductible was $120. In November she reports a pay increase of $10 a month. Now you must recalculate her MA deductible.

1. Add together the excess income of months July through October. The result is $80.

2. Calculate her November excess income. The result is excess income of $30.

3. Prospective income for December is $30.

Cicely's new MA deductible: $80 + $30 + $30 = $140.

If the income change results in **lower excess income** in the month of change, the applicant can choose to:

1. Recalculate the MA deductible, or

2. Create a new deductible period.

Example 2: Winston goes from full time to part time employment in the fourth month of his MA deductible period. He still has excess income, but it is lower than in the previous three months. He can choose either to recalculate his MA deductible or to have a new deductible period.

If he recalculates, the resulting deductible will be lower than the previous one.

His other choice is to begin a new 6-month deductible period. He may want to do this if the new deductible is even lower than the recalculated one. If he makes this choice, he will forfeit any eligibility he might have acquired in the previous deductible period if he had met the previous deductible.

If the income change results in **no excess income** the applicant has an additional choice:

1. Recalculate the deductible.

2. Create a new deductible period.

3. **Begin eligibility immediately**.

> **Example 3:** If Winston has no excess income in the month his income drops, and if his prospective monthly income shows no excess income, he can choose to begin eligibility immediately. In choosing this, he will forfeit the eligibility he would have had in the prior deductible period if he had met the prior deductible.

4.9.7.2 Group Size Changes

When the group size is different **on the last day of the month** from what it was on the last day of the previous month, you must recalculate the deductible. Compare the **new** group's income with the **new** group's medically needy income limit. If there is excess monthly income, recalculate the deductible in the same way as for income changes (4.9.7.1).

> **Example:** Maybelle and her 2 teenage daughters have a deductible. The deductible period began July 1. May-belle's 18 year old son, George, lost his job and moved in with his mother and sisters on September 10. He is still there on September 30, so you most recalculate the deductible using the larger group size. On November 2, George takes a new job and moves out of the house. If George is still out of the house on November 30, recalculate the deductible using the smaller group size.

4.9.7.3 Asset Changes

If the fiscal group acquires new assets during the deductible period, wait until the last day of the month in which it acquired the assets. If the group has excess assets on the last day of the month, the group is not eligible. End the deductible period.

4.9.7.4 Non-Financial Changes

If there is a change in non-financial eligibility during the deductible period, discontinue those persons who have become non-financially ineligible.

4.9.8 Meeting the Deductible

The fiscal test group or family fiscal unit (FFU) meets the deductible by incurring medical costs that equal the dollar amount of the deductible. The countable costs are added together. When they are equal to or greater than the amount of the deductible, the group can be certified for Medicaid.

If the group does not meet the deductible within the deductible period, it can choose to begin a new deductible period. (4.9.3)

If an expense was applied to a prior deductible but did not result in MA certification, it can be applied to a later deductible, as long as it still meets the criteria listed in 4.9.8.1.

4.9.8.1 Countable Costs

To be counted toward the deductible, a medical or remedial expense must meet all of the following conditions.

1. Be an expense for a member of the applicant/recipient's FFU (4.8.1) or FTG (5.1.5)

Expenses may be counted if incurred for someone the client is legally responsible for if that individual could be counted in the client's FTG or FFU. The medical bill may be used even if the family member is no longer living or no longer in the current FTG or FFU.

Example1: Sally's minor child Ida died of leukemia in April 2004. In September 2004, Sally requests that a medical bill incurred for Ida be used towards her deductible. Sally is still legally responsible for the bill. The bill can be used to meet the deductible as long it did not result in a Medicaid certification in an earlier period.

2. Meet the Definition of Medical or Remedial expense as defined in (4.9.8.1.1)

3. Meet one of the following four conditions

   A. Still be owed to the medical service provider sometime during the current deductible period.

      Note: Charges that are in deferred status cannot be used to satisfy a deductible unless the provider bills the client or provides a written-off date.

Example2: From May- July 2003 Helen resided in an Institute for Mental Disease (IMD) and incurred a $14,000 bill. As of October 2004, Helen has not paid this bill. In October Helen's social worker, Ruth, applies for MA on Helen's behalf.

Ruth tried to help Helen meet her deductible by collecting Helen's medical bills. The "bill" for Helen's IMD stay listed $ 14,000 in "Deferred Charges".   Ruth questioned what deferred meant. The account's receivable person at the IMD indicated that charges for low-income people are often "deferred."   "Deferred", she explained, means that the client would never be billed for the charges, but if s/he happens to come into a windfall of money (lottery or inheritance), they will change the status of those charges to current and try to collect the debt.

Helen can not use this "deferred" charge toward her deductible.   Charges in deferred status cannot be used to satisfy a deducible unless the provider bills the client, with an expectation that they will pay the bill or, writes off the bill and provides a write-off date.

Example 3: Lestat applies for MA in July, 2004. An MA deductible of $700 is calculated for him. In 2003 he had a blood transfusion. The bill for the transfusion was $800. He never paid it and still owes it to the service provider. He can use the unpaid bill to meet his MA deductible, but must provide documentation to show that the charges are currently owed. The remaining $100 can be applied to the next deductible period, as long as it is still owed.

B. Paid or written off sometime during the current deductible period. Medical bills written off through bankruptcy proceedings are not allowed as a medical expense to meet a deductible.

Example 4: Frank and Estelle apply for MA on March 1, 2004, requesting that their deductible period begin January 1, 2004. Their deductible for the period January 1 - June 30th is $340. In April, they had a ten-year-old medical bill of $300 written off. They can count the $300 toward the January - June 2004 deductible because it was written off during the deductible period.

C. Paid or written off sometime during the deductible period that immediately precedes and borders on the current deductible period. These bills can be used even if they were paid after the person met the deductible in the prior period.

Example 5: Jeffrey is in his second deductible period. He did not meet his deductible in the prior period, which borders on the current period. He has a bill that was written off in the prior period. He can apply this bill to his current deductible.

Example 6: Malcome is in his second deductible period which began March 1, 2004. He did not meet his deductible in the prior deductible period, which immediately preceded the current deductible period. He has a medical bill that he paid in February 2003. He may not apply this toward his current deductible.

Example 7: Norah is in her second deductible period which began in September 2004.. In June 2004, Norah met her deductible and was certified for MA. . After certification, and before the prior deductible period ended in August 2004, Norah paid for medical services that were not MA covered services. Norah can apply these paid bills to the deductible period the began in September 2004.

D. Paid or written off some time during the three months prior to the date of application. This expense can only be used for the first deductible period. Balances cannot be carried forward to future deductible periods.

Example 8: Mr. and Mrs. Avenue apply for MA on August 10th, 2004, requesting that their deductible period begin on August 1, 2004. Their deductible for the period from August 2004 through January 2005 is $1500. On May 10th the couple paid off a $2000 outstanding medical bill. They can use that expense to meet their deductible because it was paid in the three months prior to the date of their application. The remaining $500 cannot be applied to future deductible periods.

4.9.8.1.1 Countable Expenses

The following are expenses that can be counted against the deductible if they meet the conditions listed in 4.9.8.1:

1. Medical expenses. Medical expenses are costs for services or goods that have been prescribed or provided by a professional medical practitioner (licensed in Wisconsin or another state) regardless of whether the services or goods are covered by MA. Medical expenses for prescriptions acquired outside of the United States may be counted toward a deductible if a licensed medical practitioner or pharmacy provided the service or drug.

   Some examples of medical expenses are deductibles and co-payments for MA,for Medicare, for private health insurance; and bills for medical services which are not covered by the Wisconsin Medicaid program.

Note: MMIS data may be used to calculate MA co-payments from the previous deductible period

2. Remedial expenses. Remedial expenses are costs for services or goods that are provided for the purpose of relieving, remedying, or reducing a medical or health condition. Some examples of remedial expenses are:

   a. Case management

   b. Day care.

   c. Housing modifications for accessibility.

   d. Respite care.

   e. Supportive home care.

   f. Transportation.

   g. Community Based Residential Facility (CBRF), Adult Family/Foster Home (AFH), Residential Care Apartment Complex (RCAC), and all other community substitute care setting program costs not including room and board expenses.

   Remedial expenses do not include housing or room and board expenses.

   CBRF, AFH, RCAC, and all other community substitute care setting program costs, not including room and board expenses, can be counted as a remedial expense only as they are incurred. CBRF, AFH, RCAC and all other community substitute care setting program costs will be considered incurred as of the date that the client is billed for these expenses by the CBRF, AFH, RCAC or other community substitute care setting. The billing procedure used by the CBRF, AFH, RCAC or other community substitute care setting (one month in advance, bimonthly, etc.) for MA residents should be the same as that which is used for its non-MA residents.

   In determining how much of a CBRF, AFH, RCAC or other community substitute care setting expense can be applied to meet a medical deductible, use the facility's breakdown of the room and board versus program costs, with the program costs to be applied to the deductible.

3. Ambulance service and other medical transportation (7.1.4.1) , including attendant services (7.1.4.1.3 (12).

4. Medical insurance premiums paid by a member of the fiscal test group or

FFU. These insurance premiums include disease specific and per diem hospital and nursing home insurance payments. Do not allow accidental insurance policy premiums as a countable cost.

Note: Unlike other expenses listed in this section that may not be applied toward a deductible until they are incurred, count medical insurance premiums from the first day of the deductible period, if the premium will be coming due anytime during the current deductible period.

5. Medical bills paid by a party who is not legally liable to pay them can be counted against a deductible..

   Examples of parties that pay medical bills when not legally liable include, but are not limited to: Churches, fraternal organizations, Children's Special Health Needs Unit of the Division of Public Health, Veterans Administration and the Aids Drug Assistance Program (ADAP).

6. Medical services received at a Hill-Burton facility. The Hill-Burton Act was enacted by Congress to provide federal assistance for the construction and modernization of health care facilities. Medical facilities which receive Hill-Burton assistance must provide without charge a reasonable volume of services to persons unable to pay for those services.

7. In-kind payments. These are services or goods supplied to the provider in lieu of cash. Self declaration of the bill being satisfied is adequate verification.

4.9.8.2 Noncountable Costs

Do not count the following toward the deductible:

1. Medical bills written off through bankruptcy.

2. Medicare Supplemental Medical Insurance (Plan B) premiums if they have already been deducted from the gross social security check.

3. Medical services payable or paid for by a third party who is legally liable for the bill. This includes Bills that will be paid or have been paid by Medicaid, Medicare, or other Insurance.

   Note: Payments for recipients made by the Aids Drug Assistance Program (ADAP) are countable cost.

Example 1: Medical services provided to an incarcerated person. In this case, the incarcerating authority is the legally liable third party.

Example 2: The Indian Health Service is a legally liable third party. When it pays the person's expenses, the expenses cannot be applied to his/her deductible.

4. A bill used to meet a prior deductible. If only a portion of an unpaid bill was used to meet a prior deductible, any remaining balance that was not applied to the prior deductible, may be applied to a subsequent deductible period as long as it is still owed or meets criteria in 4.9.8.1

Example 3: The court orders a health insurer or other third party to pay for medical services.

Example 4: An applicant incurs a $300 medical bill. She applies the $300 toward her deductible even though s/he has not made any payments on the bill. She meets her deductible and is certified for Medicaid. Three years later she applies for Medicaid again and a deductible is calculated for her. She now pays the $300 bill. But she cannot use it to meet her current deductible because she already used it to meet the prior deductible.

4.9.8.3 Prepaying a Deductible

Anyone can prepay a deductible for himself/herself or for someone else. It can be paid in installments or all at once. A prepaid deductible may be refunded if the client requests a refund of the prepayment **prior** to the begin date of the corresponding deductible period.

If the client is 55 or older, forward the payment to:

Estate Recovery/Casualty Collections
6406 Bridge Road
Madison WI 53784-0013

Prepayment checks or money orders should be made payable to: “The Department of Health and Family Services.”

With the payment, include:

1. Documentation that the payment is voluntary.

2. The client’s name and MA ID number.

If s/he is **under 55**, instruct the client to make the payment payable to your ESA. Report the receipt on the Community Aids Reporting System (CARS) on Line

909.

4.9.8.3.1 Payment of Entire Deductible Amount

If the entire deductible amount is paid at any point during the deductible period, eligibility begins on the first date of the deductible period.

> **Example:** Laura's deductible period is from March 1st through August 31st. The total deductible amount is $1,000. Laura submits payment of $1,000 on August 15th. Laura's MA eligibility begins on March 1st.

Enter the first date of the deductible period on AGTM as the date the payment was received.

4.9.8.3.2 Combination of Payment and Incurred Expenses

If the deductible is met through a combination of payment and incurred medical expenses, count the incurred medical expenses first. Eligibility, by paying the remaining deductible amount, can begin no earlier than the last date of incurred medical expense within the deductible period.

> **Example:** Chad's deductible period is from March 1st through August 31st. The total MA deductible amount is $1,800. Chad submits a medical bill with a March 8th date of service for $800. On July 15th, he submits payment of $1,000. Chad's MA eligibility begins March 8th. Submit a Medicaid Remaining Deductible Update (HCF 10109) identifying the provider of service on March 8th and the $800 client share amount.

Enter the incurred medical expense first. Perform a PF23 sort. The remaining balance is the amount that can be paid to meet the deductible. Enter the payment date as the same date of the last incurred medical expense, which equals the balance of the deductible, on CARES screen AGTM. Complete and submit a Medicaid Remaining Deductible Update (HCF 10109) to EDS. Enter the deductible met date as the date of the last incurred medical expense. Enter the client share as the amount of the last incurred medical expense.

4.9.8.3.3 Combination of Payment and Outstanding Expenses

If the deductible is met through a combination of payment and outstanding medical expenses (incurred prior to the beginning of the deductible period), eligibility begins on the first date of the deductible period.

> **Example**: Roberta's deductible period is from March 1st through August 31st. The total MA deductible amount is $1,500. She submits an outstanding bill from January 10th for $500. On August 15th, she submits payment of $1,000. Roberta's MA eligibility begins March 1st

Enter the first date of the deductible period on AGTM as the date the payment was received.

4.9.8.3.4 Calculation Errors

If any portion of the deductible is paid and you find the amount was wrong due to agency error, refund the paid amount that was incorrect and report the refund on CARS.

4.9.8.3.5 Insufficient Funds

If the deductible is paid with a check that is returned for insufficient funds, discontinue the person's eligibility, determine if an overpayment occurred and if so, establish a claim for benefit recovery.

This page last updated in Release Number: 05-01
Release Date:01-11-05
Effective Date: 01-11-05

4.9.9 Order of Bill Deduction

When applying medical bills to the deductible, start with the earliest service date. If more than one bill has the same service date, use the bill with the highest amount first, then the next highest and so on down to the lowest bill with that same service date.

4.9.9.1 Hospital Bills

Hospitals do not always itemize the cost of their services according to the day and time of day the patient received the services. It is difficult sometimes to know when the patient met the deductible.

For this reason, if the patient’s hospital bill for one continuous stay in the hospital is equal to or above whatever the deductible was on the date of admission, count the deductible as having been met on the date of admission. Set that date as the begin date of MA certification. Apply the hospital bill to the deductible first before counting any other medical costs that were incurred during the hospital stay.

Example: Linda submits a $2,000 bill toward her deductible, for hospitalization from July 12th through July 14th. She also submits a physician bill for $2,500 with a date of service of July 12th. Apply the $2,000 hospital bill to the deductible first.

4.9.9.2 Pregnancy Fees

Many providers charge a flat fee for pregnancy related services. The single-fee includes all prenatal care, office visits, delivery, and postnatal care.

In determining whether these "global" pregnancy fees meet the deductible, treat them the same way as you would a hospital bill. If the "global" pregnancy fee is equal to or above the deductible, count the deductible as having been met as of the date an agreement was signed.

This page last updated in Release Number: 03-02
Release Date:04-01-03

4.9.10 Notice to EDS

When the client receives a medical bill that is equal to or greater than the amount s/he still owes on the deductible, s/he can be certified for MA. S/he must pay the part of the bill that equals the deductible. MA will consider the remainder of the bill for payment.

To make sure that MA does not pay what the client still owes on the deductible, send a Medicaid Remaining Deductible Update (HCF 10109) to EDS indicating the amount of the bill that the client owes. EDS subtracts this amount from the bill and MA pays the rest.

Fill out the Medicaid Remaining Deductible Update (HCF 10109) only if:

1. A MA certified provider has provided the billed services.

2. The person, having met the deductible, is being certified. If s/he is not being certified, MA will not pay any of the bill.

The date of the bill is the date the deductible was met. Since the client is not eligible until s/he has met the deductible, s/he still owes for all bills prior to that date.

Do not send more than one bill. In the series of bills which the client may submit to you, there will be only one bill which is larger than the amount needed to meet the deductible. MA will consider the remainder of the bill for payment.

This page last updated in Release Number: 03-02
Release Date:04-01-03
Effective Date: 04/01/03

4.9.11 Late Reports

If the client turns in late reports on income changes or medical costs, recalculate the deductible as of the date the change took place or the medical cost was incurred. See what would have been the deductible had s/he reported the changes and the medical costs as they occurred. If the medical bills would have met the deductible for any past date, begin MA certification on that date.

This page last updated in Release Number: 03-02
Release Date:04-01-03
Effective Date: 04/01/03

4.9.12 inter Agency transfer

When a MA group, having met the deductible, moves to another county or tribal area, do not transfer the case to the new agency unless there is a change that requires a review.

Example 1: John Restless and family are receiving MA after having met a deductible. John moves himself and his family from Waupaca County to Vilas County. There are no other changes in the case. Waupaca County keeps the case until the deductible period expires.

Example 2: The Sans Pareil family is receiving MA after having met a deductible in Grant County. They move to Polk County after reporting a change in assets to their Grant County ESS. Polk County must do the review and take over the case, even if the change does not affect the Sans Pareil's eligibility.

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

4.9.13 Changes after Meeting the Deductible

When the fiscal group has met the deductible, it can be certified for MA to the end of the deductible period.

4.9.13.1 Income Changes

Income changes do not affect the group's eligibility for the remainder of the deductible period.

4.9.13.2 Asset Changes

If the MA group acquires new assets during the remainder of the deductible period, wait until the last day of the month in which it acquired the assets. If the group has excess assets on the last day of the month, discontinue MA eligibility.

4.9.13.3 Non-Financial Changes

If there is a change in non-financial eligibility during the remainder of the deductible period, discontinue those persons who have become non-financially ineligible.

If a child enters the MA group, the child's name will appear on the MA card for the remainder of the deductible period.

If an adult caretaker relative (3.5.1.1) who is EBD or is medically verified as pregnant enters the MA group, his/her name will appear on the MA card for the remainder of the deductible period.

If a client loses non-financial eligibility and regains it during the same deductible period, the client may choose to be re-certified for the remainder of the deductible period or reapply and establish a new deductible period if his or her income still exceeds the appropriate Medicaid income limit.

This page last updated in Release Number: 05-01
Release Date:01-11-05
Effective Date: 01-11-05

4.9.14 Death

If the client dies during the deductible period, and is not already certified, look at all countable costs (4.9.8.1) prior to death. If those countable costs meet the deductible, certify the dead person. The time period for the deductible remains six months (no prorating). All months that remain of the six-month deductible period from the point the client dies, are considered to have $0 income. The deductible amount should be recalculated. If the deductible was met, eligibility will be the point from which eligibility was determined to have been met through the date of death.

4.9.14.1 Prepaid

If the client prepays the deductible and dies after the deductible period starts, the deductible is non-refundable. If the client prepays and dies before the deductible period starts, the deductible is refundable.

This page last updated in Release Number: 03-02
Release Date:04-01-03
Effective Date: 04/01/03

5 SPECIFIC PROGRAMS

Explanation of MA Cascade

5.1 CASCADE

5.1.1 Cascade Definition

The MA cascade is the hierarchy of eligibility.

This page last updated in Release Number : 01-05
Release Date: 10/01/01
Effective Date: 10/01/01

5.1.2 MA Categories

There are 3 major categories of MA. They are:

1. Family MA - This includes AFDC MA, AFDC-Related MA, Extensions, Healthy Start and BadgerCare. This group includes children <19, caretaker relatives, and pregnant women.

2. Elderly/Disabled MA - This includes SSI-Related MA, SSI MA, Katie Beckett, TB-related, Institutions and Community Waivers cases. This group includes people 65 or older, and those determined disabled by the Disability Determination Bureau (3.6.1). The exception is institutions cases. There can be non-elderly/disabled (i.e. children) in those cases.

3. Others - This includes QMB, SLMB, SLMB+, QDWI, Emergency MA and Presumptive Eligibility.

5.1.2.1 Categorical Definitions

Categorically related - A person may fit into one of the above 3 categories based on nonfinancial factors. For example, a 70 year old would be categorically related to the elderly/disabled category.

Categorically eligible - These people are eligible based on the receipt of another public assistance program such as SSI, Federal Title IV-E Foster care, and Adoption Assistance.

This page last updated in Release Number : 01-05
Release Date: 10/01/01
Effective Date: 10/01/01

5.1.3 Assistance Group

The group includes all people in the household who are requesting MA and those who are pulled in by their relationship to the requestor.

This page last updated in Release Number : 01-05
Release Date: 10/01/01
Effective Date: 10/01/01

5.1.4 MA Group

The MA group are those in a household who are nonfinancially eligible for MA.

This page last updated in Release Number : 01-05
Release Date: 10/01/01
Effective Date: 10/01/01

5.1.5 Fiscal Test Group (FTG)

The FTG are those within an AG whose income, assets and presence are counted when determining eligibility. The composition of the FTG may be different for each category of assistance being tested.

5.1.5.1 Family MA

The fiscal test group consists of the:

1. MA group.
2. Each fetus of a pregnant woman (except AFDC-MA).
3. Someone in the household, but outside of the MA group, who has legal responsibility for someone in the group.

5.1.5.2 Elderly/Disabled

Non-Institutionalized/Non-Community Waivers - The FTG is the primary person, and his/her spouse.

Institutionalized/Waivers - The FTG is the Institutionalized/Waivers person only.

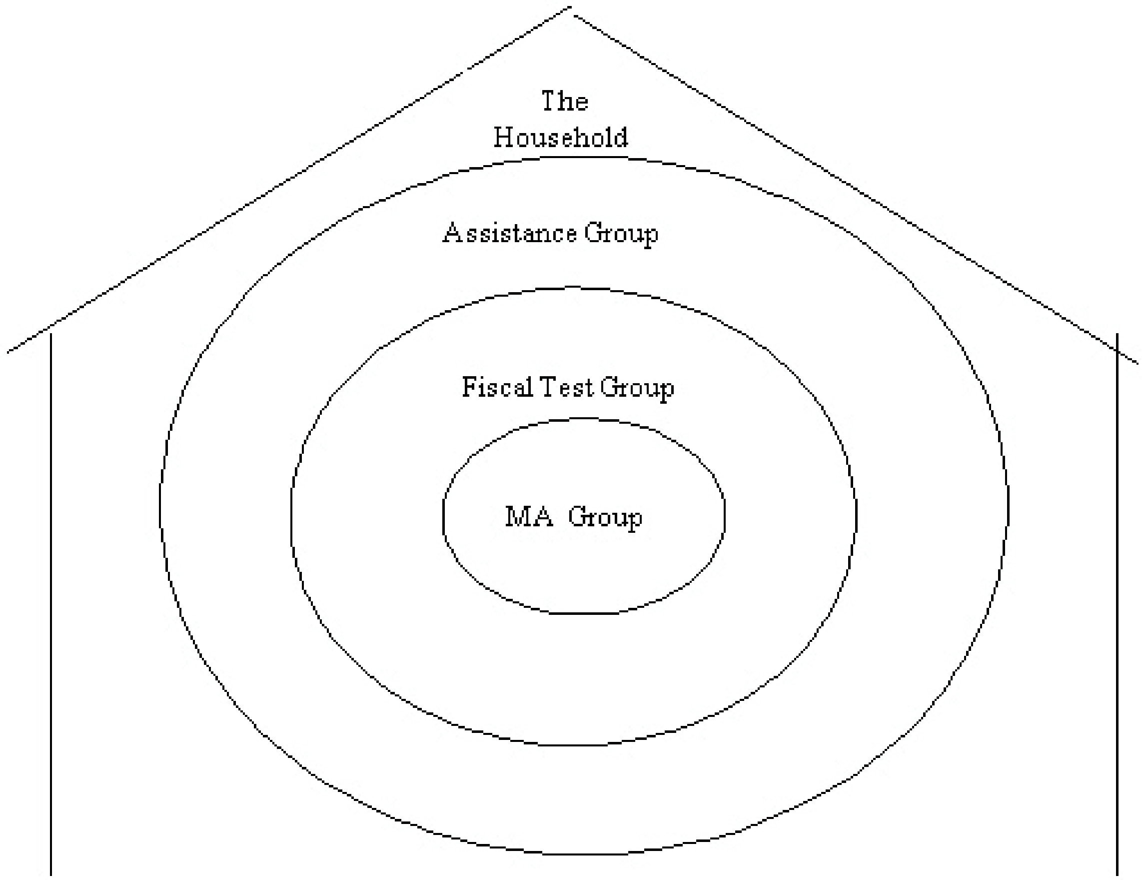
5.1.5.3 Others

The FTG for QMB, SLMB, SLMB+, and QDWI is the primary person and his/her spouse.

TB - The FTG is only the primary person.

PE - See 5.1.5.1.

Emergency MA - For elderly/disabled, see 5.1.5.2. For pregnant women, children or caretakers, see 5.1.5.1.



This page last updated in Release Number: 02-03
Release Date: 07/01/02
Effective Date: 07/01/02

5.1.6 Participation Status Codes

The following are the abbreviations which you will see in CARES that explain each person's status in the case. These describe who is in or out of the FTG, and how that person's income and assets are counted

AA ALLOCATED ADULT - An adult who is ineligible for AFDC-MA but someone in the MA group is legally responsible for this adult. S/he is not in the FTG. S/he receives income from a spouse in the MA group.

AC ALLOCATED CHILD - A child who is ineligible for AFDC-MA, but someone in the MA group is legally responsible for this child. S/he is not in the FTG. S/he receives income from a parent in the MA group.

AD ALIEN SPONSOR DEEMER - A person who supports an alien's entry into the U.S. S/he is not in the AFDC-MA group or FTG. Add his/her income to the MA group after deductions. The AD only applies to AFDC-MA.

CA COUNTED ADULT - An adult who is ineligible for MA but legally responsible for someone in the MA group. S/he is part of the FTG. Count his/her income and assets.

CC COUNTED CHILD - A child who is ineligible for MA but legally responsible for someone in the MA group. S/he is part of the FTG. Count his/her income and assets.

CD COMMUNITY DEPENDENT - In spousal impoverishment cases only, this is the tax dependent living with community spouse. Income is subtracted from the institutionalized spouse in post-eligibility to calculate the family member income allowance. The dependent is not in the FTG, and do not count his/her income and assets.

CS COMMUNITY SPOUSE - In spousal impoverishment cases only, this is the spouse of an institutionalized person living in the community. Count his/her assets for the initial spousal impoverishment determinations only, never thereafter. The institutionalized spouse can allocate income in post-eligibility treatment of income. The CS is not in the FTG.

EA ELIGIBLE ADULT An adult who is non-financially eligible and part of the MA group. S/he is in the FTG. Count his/her income and assets.

EC ELIGIBLE CHILD A child who is non-financially eligible and part of the MA group. S/he is in the FTG. Count his/her income and assets.

FL FISCAL ALLOCATOR Person who has legal responsibility to someone in the FFU. This person's income and assets are allocated by the number of people for whom s/he is legally responsible and themself. This only relates to FFU.

FM FISCAL MEMBER - Person (not the FFU target) for whom a fiscal allocator is legally responsible. S/he receives income and assets from the fiscal allocator when determining FFU. This only relates to FFU.

PD PARENT DEEMER - Person is ineligible for a reason other than non-cooperation with TPL, CS, SSN, or MSL. S/he is not in the FTG, but count his/her income after subtracting an amount for their needs. Count his/her assets. Applies to AFDC-MA only.

SD SANCTIONED DEEMER - Legally responsible for an MA group member. This person is ineligible because of non-cooperation with TPL, CS, SSN or MSL. S/he is not in FTG or MA group. Count his/her income, allowing deductions except the earned income one, and assets. This only applies to AFDC-MA.

SI INCOME SPOUSE - The spouse of the Medicaid Purchase Plan (MAPP) applicant is always considered the “income spouse” (as long as they live together). In a household in which both spouses are applying for MAPP, the husband will be considered the wife’s income spouse and the wife will be considered the husband’s income spouse.

TC TEST CHILD - Test children only apply to BC and MAPP. For BC, the test child is ineligible for BC solely because of insurance access or coverage, or because s/he’s on another type of MA.

> For MAPP, the test child is any natural or adoptive child of the MAPP client. S/he is part of the FTG. For both BC and MAPP, do not count the test child(ren)’s income and assets.

TD STEPPARENT DEEMER - A TD is an ineligible stepparent who is married to a MA group member. Count his/her income, minus income set aside to meet the needs of the spouse and children. Do not count his/her assets or include him/her in the FTG. Applies to AFDC-MA only.

XA EXCLUDED ADULT - An adult who is not requesting MA/BC and is not legally responsible for an eligible group member. S/he is not part of the FTG. Do not count his/her income or assets.

XC EXCLUDED CHILD - A child who is not requesting MA/BC and is not legally responsible for an eligible group member. S/he is not part of the FTG. Do not count his/her income or assets.

5.1.6.1 Table Definitions

CARES Part Status Code = The participation status code that CARES uses to determine how the individual relates to the Medicaid Group, Fiscal Test Group or Family Fiscal Unit.

Term = The words that are used to describe this Medicaid filing unit concept.

Definition = A description of what types of individuals and under what circumstances this term is applied to an individual.

AFDC-Medicaid Only = Describes whether this filing unit term only applies to the AFDC-Medicaid group.

FFU Only = Describes whether this filing unit term only applies to the Family

Fiscal Unit policies and processes.

MA Group = Describes whether this type of filing unit participation status is included in the Medicaid group.

FTG = Describes whether this type of filing unit participation status is included in the Medicaid Fiscal Test Group and thus increase the group size.

Count their income – Giver = Describes whether an individual with this filing unit participation status provides money to individuals whose income is counted in the determination of eligibility.

Count their income – Receiver = Describes whether an individual with this filing unit participation status is provided money by individuals outside of the group in the determination of eligibility.

Count Their Assets = Describes how the assets of an individual with this filing unit participation status are treated.

CARES Part Stat Code	Term	Definition	AFDC-MA Only	FFU Only	MA group	FTG	Count Their Income		Count Their Assets
							Giver	**Receiver**	
AA	Allocated Adult	Someone, ineligible for AFDC-Medicaid, for whom a person in the AFDC-Medicaid group is legally responsible	Yes	NA	No	No	-	Receiving income from a spouse in the AFDC-Medicaid Group	No
AC	Allocated Child	A child (not deprived) ineligible for AFDC-Medicaid whose parent is in the AFDC-Medicaid group is legally	Yes	NA	No	No	-	Receiving income from a parent in the AFDC-Medicaid Group	No

		responsible.							
AD	Alien Sponsor Deemer	An individual agreeing to support an alien who has entered the USA	Yes	NA	No	No	Count their income after deductions	-	Count their assets (minus set aside
CA	Counted Adult	An adult ineligible for Medicaid who is legally responsible for someone in the Medicaid group.	No	NA	No	Yes	Count their income	-	Count their assets
CC	Counted Child	A child ineligible for Medicaid who is legally responsible for someone in the Medicaid group.	No	NA	No	Yes	Count their income	-	Count their assets
CD	Community Dependent	Spousal Impoverishment Only A tax dependent living with the community spouse	No	NA	No	No	-	Subtract income in the inst'lized spouse's post-eligibility treatment of income equal to the calculated Family Member Income Allowance	No
S	Community Spouse	Community Spouse	No		No	No	-	Subtract income in the inst'lized spouse's post-eligibility treatment of income equal to the amount actually	Count the spouse's assets only in the initial determination of the institutionalized

								made available to the community spouse as the Community Spouse Income Allocation	spouse's Medicaid eligibility
EA	Eligible Adult	An adult who is non-financially eligible for Medicaid.	No		Yes	Yes	Count their income	Count their income	Count their assets
EC	Eligible Child	A child who is non-financially eligible for Medicaid.	No		Yes	Yes	Count their income	Count their income	Count their assets
FL	Fiscal Allocator	A person who is legally responsible for the individual in the FFU AG.	No	YES – included in group size	No	NA	Count their income for the person for whom they are legally responsible after dividing their total income by the number of persons in the household for whom they are legally responsible		Count their assets for the person for whom they are legally responsible after dividing their assets by the number of persons in the household for whom they are legally responsible plus themselves
FM	Fiscal Member	A person, not the FFU target, for whom a fiscal allocator is legally responsible.	No	Yes- included in group size	No	NA		Receives income from LRR after division of income by number of individuals for whom the fiscal allocator is legally responsible plus the LRR.	Receives assets from LRR after division of assets by number of individuals for whom the fiscal allocator is legally

									responsible plus the LRR.
PD	Parent Deemer	This person is ineligible for a reason other than non-cooperation with child support, TPL, MSL or SSN requirements and is legally responsible for someone in the group.	Yes	NA	No	No	Count their income after subtracting an amount for their needs.		Count their assets
SD	Sanctioned Deemers	This person is ineligible because of non-cooperation with child support, TPL, MSL or SSN requirements and is legally responsible for someone in the group.	Yes	NA	No	No	Count their income allowing all deductions except the earned income deduction.		Count their assets
SI	Income Spouse	MAPP Only The spouse of the applicant in a MAPP case (as long as they live together).	NA	NA	No	Yes	Yes	Yes	No
TC	Test Child	BadgerCare and MAPP Only For BC, a child who is ineligible solely because of health insurance coverage or access, or is on another type of MA. For MAPP, any natural or adoptive child of the MAPP client. Include in the group size.	No	NA	No	Yes	No	No	No

TD	Stepparent Deemer	An ineligible stepparent with a spouse in the AFDC-Medicaid group.	Yes	NA	No	No	Count income minus income set aside to meet the needs of the spouse and his/her children.		No
XA	Excluded Adult	An adult who is either not requesting MA/BC or is non-financially ineligible and not a LRR for a MA Group member.	No	NA	No	No	No	No	No
XC	Excluded Child	A child who is either not requesting MA/BC or is non-financially ineligible and not a LRR for a MA Group member.	No	NA	No	No	No	No	No

* Listed below are explanations of what the "Giver" and "Receiver" mean under the "Count Their Income" heading:

1. Giver – When the individual being described is not in the MA group.
2. Receiver – When the individual being described is in the MA group.

This page last updated in Release Number : 02-03
Release Date : 07/01/02
Effective Date : 07/01/02

5.1.7 Process

Run the fiscal test group through the cascade . Test for categorically (ca) needy first all the way through (except FFU). Then go back and test if medically (med) needy at each step of the cascade.

Cat Needy - People are eligible using lower asset and income limits.

Med Needy - People are eligible using higher asset and income limits.

5.1.7.1 Hierarchy

Below is the cascade hierarchy that incorporates EBD MA and Family MA. If you have a mixed family, follow this cascade. Once you find someone eligible, you do not have to continue testing his or her eligibility. Continue to test remaining group members.

1. MA Institutions Cat Needy Protected (MI C, MI D, MI W, MI T)
2. MA Institutions Cat Needy (MI S, MI M, MI A, MI P, MI R)
3. MA Institutions Med Needy Protected (MI C, MI D, MI W, MI T)
4. MA Institutions Med Needy (MI S, MI P, MI R)
5. AFDC-MA (MA U or MA R)
6. MA Extension Cat Needy (ME I, ME C, ME T, ME D)
7. Continuously Eligible Newborn Cat Needy (MN)
8. AFDC-Related Cat Needy (MAOU, MAOR)
9. Pregnancy Extension Cat Needy (ME P)
10. Healthy Start Cat Needy (MHSP, MHSC, MHSN,)
11. SSI-Related Protected MA Cat Needy (MP C, MP D, MP W, MP T)
12. SSI-Related Cat Needy (MS)
13. AFDC-Related Med Needy (NAOR)
14. Continuously Eligible Newborn Med Needy (NN)
15. Healthy Start Med Needy (NHSC, NHSP)
16. Pregnancy Extension (NE P)
17. SSI-Related Protected MA Med Needy (NP C, NP D, NP W, NP T)
18. SSI-Related Med Needy (NS)
19. AFDC-Related Med Needy Deductible (NAOR MD)
20. Healthy Start Med Needy Deductible (NHSC MD)
21. SSI-Related Med Needy Deductible (NS MD)
22. Medicaid Purchase Plan (MAPP)
23. BadgerCare (BC)
24. Community Waivers: CIP IA (MCWA)
   Community Waivers: CIP IB (MCWB)
   Community Waivers: CIP II (MCWE) Community Waivers: COP Waiver (MCWW)
   Community Care for Elderly (CCE)
   Community Supported Living Arrangement (CSLA)
   Brain Injury Waiver (MCWI)
   PACE (MCWP)
   Partnership (MCWR)

25. Family Planning Waiver (FPW)
26. QMB only (QMB, QMBN)
27. SLMB only (SLB)
28. SLMB+ (qualifying individuals 1)
29. ALMB (qualifying individuals 2)
30. QDWI only (QDWI)
31. Family Care Non-MA

5.1.7.2 EBD Cascade

Use this cascade when you have an Elderly, Blind, Disabled (EBD) case that does not include anyone potentially eligible for Family MA.

Institutions Cat Needy Protected

Institutions Cat Needy

Institutions Med Needy Protected

Institutions Med Needy

SSI-Related Cat Needy Protected

SSI-Related Cat Needy

SSI-Related Med Needy Protected

SSI-Related Med Needy

SSI-Related Med Needy Deductible

Medicaid Purchase Plan (MAPP)

Community Waivers

TB-Related

QMB

SLMB

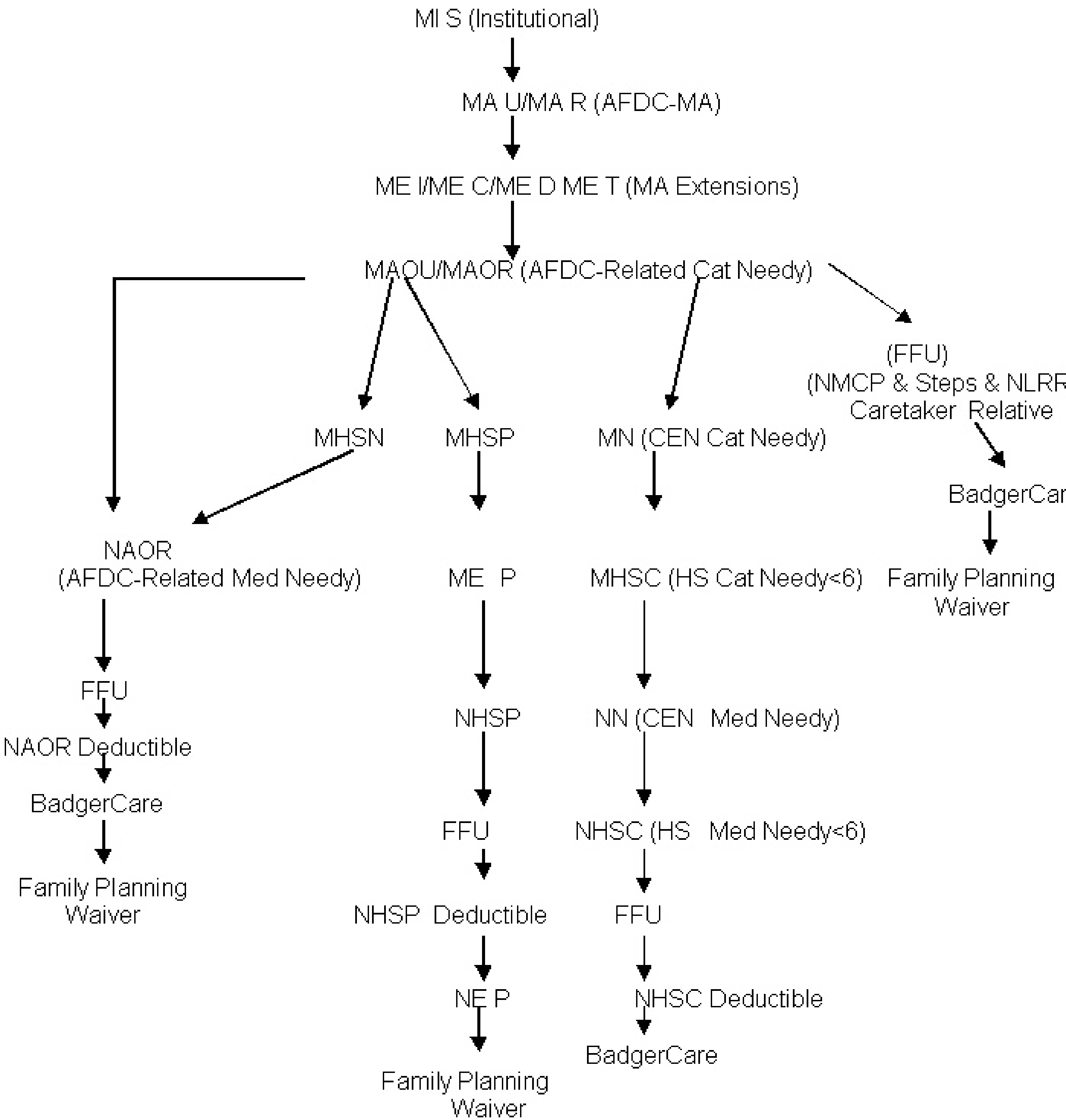
SLMB+

ALMB

QDWI

5.1.7.3 Family Cascade

Use this cascade when testing MA for children, caretaker relatives and pregnant women. If you have someone else in the case who is EBD use the cascade at 5.1.7.1.


MI S (Institutional)
MA U/MA R (AFDC-MA)
ME I/ME C/ME D ME T (MA Extensions)
MAOU/MAOR (AFDC-Related Cat Needy)
(FFU)
(NMCP & Steps & NLRR
Caretaker Relative
MHSN
MHSP
MN (CEN Cat Needy)
BadgerCar
NAOR
(AFDC-Related Med Needy)
ME P
MHSC (HS Cat Needy<6)
Family Planning
Waiver
FFU
NHSP
NN (CEN Med Needy)
NAOR Deductible
BadgerCare
FFU
NHSC (HS Med Needy<6)
Family Planning
Waiver
NHSP Deductible
FFU
NE P
NHSC Deductible
BadgerCare
Family Planning
Waiver

Run the FTG through the cascade. Test cat needy first all the way through (except FFU). Then go back and test if med needy at each step of the cascade. After you test MAOU and MAOR (AFDC-Related cat needy), the process changes dependent upon the child's age or if a group member is pregnant.

5.1.7.3.1 Child Under 6

Test the child for Healthy Start following this sequence:
MA R/MA U, MAOR/MAOU, MN, MHSC, NN, and then NHSC. Do not test this child for AFDC-Related med needy (NAOR). If the child fails, then go to FFU if applicable (4.8.1). If s/he fails FFU, determine the deductible.

5.1.7.3.2 Child 6 through 18

Test the child (ages 6 through 18) for Healthy Start if they fail MAOU/MAOR. If the FTG fails, then go to FFU, if applicable (4.8.1). If they fail MHSN, there is no med needy Healthy Start test. S/he can only be eligible by meeting a AFDC-Related deductible. Use the AFDC-Related med needy limit to determine the deductible amount for the child.

5.1.7.3.3 18-Year-Olds

An 18-year-old is an adult so parents are not legally responsible for them. Determine their eligibility without counting the parent's income. Include an 18-year-old's spouse in the FTG if the spouse is living with the 18-year-old.

If parents or caretaker relatives of an 18-year-old want MA, they can be eligible if the following three are true:

1. They are living with the 18-year-old.
2. They request to be included in the group.
3. The group meets all other non-financial and financial requirements.

The following programs have some additional requirements:

a. **AFDC MA and AFDC-Related MA** - The 18-year-old must meet the dependent 18-year-old criteria (3.5.1.3).
b. **BadgerCare** - Caretaker relatives (other than parents) are ineligible for BadgerCare.

If the group with the parents/caretaker relative fails financial requirements, test the 18-year-old separately. S/he can be determined as cat needy or med needy for AFDC-Related MA if s/he met the dependent 18-year-old criteria.

If the 18-year-old is not a dependent 18-year-old, only test for cat needy AFDC-Related MA, Healthy Start and BadgerCare.

If the 18-year-old is blind, disabled, pregnant, or a parent caretaker of a minor, then test eligibility for the relevant category of MA.

Disregard the earned income of 18-year-olds who meet the criteria listed in 4.1.5.9.

5.1.7.3.4 Pregnant Woman

Test a pregnant woman for MA U/MA R. If she fails MAOU/MAOR, go to Healthy Start cat needy (MHSP). If she fails, test her following this sequence: ME P, NHSP, and NE P. If she fails all of those, go to Family Fiscal Unit (FFU) testing. If she fails FFU, determine the deductible.

5.1.7.3.5 FFU

The Family Fiscal Unit (FFU) policy is an individual-based test of eligibility.

Apply the FFU test if the AG fails regular AFDC-Related and Healthy Start testing because of income, and only if the group contains a:

1. Pregnant woman.
2. Child with income.
3. Stepparent.
4. Non-Marital Co-Parent (NMCP).
5. Non-Legally Responsible (NLRR) child.

See Chapter 4.8.1.

This page last updated in Release Number : 03-01
Release Date : 01/01/03
Effective Date : 01/01/03

FAMILY MEDICAID

5.2 HEALTHY START

5.2.1 who qualifies

Pregnant women, and children age 18 and under qualify for Healthy Start MA if they:

1. Are non-financially eligible (5.2.2), and
2. Pass the Healthy Start financial tests (5.2.3).

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

5.2.2. Non-Financial Tests

To be non-financially eligible they must meet all the general MA non-financial requirements in 1.1.2.

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

5.2.3 Financial Tests

5.2.3.1 Assets

There is no Healthy Start asset test.

5.2.3.2 Income

Count income and income disregards the same way as you do in AFDC-Related MA. Use the table at 8.1.6 to determine income limits. Test pregnant women and children under six years of age against the 133% FPL limits for categorically needy and against the 185% limits for medically needy. Test children ages six through 18 against the 100% FPL limits.

If the group has a pregnant woman, include the fetus when determining the FTG size for both the mom and children.

If any non-financially eligible individual fails and the FTG contains one of the following, go to FFU testing (4.8):

1. Pregnant woman.
2. Child with income.
3. Stepparent.

4. Non-marital co-parent. (NMCP)
5. Non-legally responsible child.

If it does not contain one of the above and fails, determine a deductible (4.9). Use the medically needy income limit. Do not determine a deductible for caretakers.

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

5.2.4 Presumptive Eligibility for Pregnant Women

Presumptive Eligibility (PE) for pregnant women provides pregnant U.S. citizens with ambulatory prenatal care under MA, beginning on the day that a qualified provider:

1. Medically verifies the pregnancy.

2. Determines that the woman's family income does not exceed the PE for pregnant women income limit.

The provider should refer non-citizens to the Economic Support Agency (ESA) for a MA eligibility determination.

Qualified providers are certified under a contract with the Division of Health Care Financing (DHCF). A qualified provider will determine if a pregnant woman is presumptively eligible for MA.

If she is, the qualified provider will:

1. Assist the woman in completing and signing the Medicaid Presumptive Eligibility Application for Pregnant Women (HCF 10081).

2. Fill out the temporary MA ID card at the bottom of the application form. The certification dates will be from the date PE for pregnant women is determined through the end of the month following the month the determination is made.

3. Give the woman a temporary MA ID card.

4. Explain that the duration of her PE for pregnant women period depends on when she applies for MA at her ESA.

    a. If she applies for MA by the end of the month following the month in which she became eligible for PE for pregnant women, the PE for pregnant women period ends the day on which the agency completes processing her application.

b. If she does not apply by the end of the month following the month in which she became eligible for PE for pregnant women, the PE for pregnant women period ends the last day of the month following the month in which she was determined eligible for PE for pregnant women. If she is found ineligible for MA, her PE for pregnant women will end following adverse action notice.

5. Send a copy of the completed application form to EDS and the ESA within five days.

5.2.4.1 At the ESA

If the woman applies for MA at the ESA on or before the last day of her PE for pregnant women period:

1. Verify she is presumptively eligible by checking her temporary MA ID card.

   Assist her in filing the application. Consider the application filed if her name, address and signature are on the application.

2. If you are unable to finish processing her application by the end of her PE for pregnant women period, extend her PE for pregnant women period for an additional calendar month. Do the following:

   a. After the "PE Extension" on the temporary MA card, write a date that is 30 days after the "Thru" date.

   b. Stamp or write your agency's ID number and name on the temporary MA ID card. Return the card to the woman.

Complete a Medicaid/BadgerCare Certification form (HCF 10110, former DES 3070) and send to EDS. The medical status code is "PE" for categorically needy, "P2" for medically needy. Enter the extended date for the PE for pregnant women.

If she is found ineligible for MA, complete a negative notice (HCF 16001) to end the PE for pregnant women segment. Check box three and complete the sentence to read: "Your presumptive eligibility for pregnant women benefits will be stopped effective (write in date)". Under "Explanation of Action," write the reason MA is being denied. Mail one copy to the woman and one to the qualified provider. Complete a Medicaid/BadgerCare Certification form HCF 11010 (formerly DES 3070), indicating the PE for pregnant women end date, and send to EDS.

If the woman does not apply for MA, or applies after the end of the month following the month in which she was determined eligible for PE for pregnant women, her PE for pregnant women ends with no extension. Sending a negative notice is not necessary. If she applies after the end of the month following the month she was determined eligible, process the application as you would a standard MA application.

5.2.4.2 Assets and Income

PE for pregnant women has no asset limit. The categorically needy limit is 133% of the FPL and medically needy income limit is 185% of the FPL. See 8.1.6.

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

5.2.5 Newborn Child

Newborn children are automatically eligible for MA if:

1. They are under age 13 months.
2. The natural mother was determined eligible for full-benefit MA (7.1.2) from the State of Wisconsin on the date of delivery.

> **Example:** Ms. M. gave birth on April 15, 1992. On June 15, 1992 she applied for MA. Her eligibility was backdated to March 15, 1992. Her infant son is eligible from April 15, 1992 through April 30, 1993, the end of the month in which he turns one year old.

The newborn child does not receive this automatic eligibility if the mother's MA certification is under presumptive eligibility (5.2.4) or as an ineligible alien (3.2.2).

3. They are continuously living with the natural mother. If the child moves out of state or ceases to live continuously with the natural mother, s/he loses eligibility and cannot recover it.

The child is not required to have a SSN.

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

5.2.6. Certification Period

5.2.6.1 Pregnant Women

Begin Date. Backdate the certification to the first of the month, three months before the month of application. If the pregnancy is more recent, backdate to the first of the month in which the pregnancy began.

If a woman was pregnant before the date of her application, backdate her MA, even though she is not pregnant on the date of application. Do not, however, give her an extension.

Before backdating her MA, verify that she met all eligibility requirements during the retroactive period.

End Date. A pregnant woman stays eligible for the balance of the pregnancy and for an additional 60 days. Eligibility continues to the end of the month in which the 60th day occurs (5.6.5).

Example: A pregnant woman and her ten-year-old child apply on January 15, 1993. She fails regular categorically needy MA, but qualifies for Healthy Start categorically needy. She delivers on March 10, 1993. Sixty days after the last day of pregnancy is May 9, 1993. Her eligibility continues through May 31, 1993.

During the pregnancy and 60-day extension, an increase in family income does not cause her to lose MA. Once found eligible, she remains income eligible for the pregnancy and 60 day extension. She does not have to meet a deductible for any months after she is found eligible.

If a BC case closes due to excess income prior to the end of the pregnancy, certify the pregnant woman manually using the PW or P1 med stat code. If the BC case closes during the 60-day extension period, use the E3 or E4 med stat code.

If she moves to another state during the 60-day extension period, her eligibility ends. Reinstate the extension, if she moves back into the state and becomes a resident again.

If the time period of the extension expires while the person is out-of-state, she does not regain the extension.

5.2.6.2 Newborn Child

Begin Date. For a newborn child, MA begins on the date of birth. It does not matter when the birth was reported.

End Date. The MA end date is:

1. The end of the month in which the child turns one-year-old, **or**

2. The date the child ceases to live continuously with his/her natural mother,

or

3. The date s/he becomes non-financially ineligible.

Changes in the fiscal group's income have no effect on the child's eligibility during the certification period.

5.2.6.3 Child Under Age 6

Begin Date. The MA begin date is the first day of the month in which the child meets all eligibility factors.

End Date. The child remains eligible through the end of the month in which his/her sixth birthday occurs. S/he must continue to meet the Healthy Start income test.

If s/he fails the Healthy Start medically needy income test anytime before his/her sixth birthday, close the case. On the day the child turns six, apply the six or over limits (8.1.6).

5.2.6.4 Children 6 through 18

Begin Date. The MA begin date is the first day of the month in which the child meets all eligibility factors.

End Date. Certify through the next review, or as long as all non-financial and financial eligibility factors remain unchanged.

5.2.6.5 Children in an Institution

A Healthy Start child of any age who resides in an acute care hospital remains eligible until the end of his/her stay. Disregard changes in income.

If s/he is an inpatient in a facility other than an acute care hospital, test him/her as an institutionalized child first. Certify him/her under Healthy Start only if s/he fails as an institutionalized child.

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

5.2.7. Inter-Agency Transfers

When a person on Healthy Start moves to another county or tribal area, transfer the case to the new agency. The agency that the client reports the move to must collect information about the changes, for example, the new address. If the agency does not have sufficient information about the changed circumstances, it must request information from the client, according to the MA verification policy (1.2).

CARES will automatically set a review date for one month after any changes are made. Correct the review date in CARES, so that it is the end of certification period. Run eligibility in CARES.

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

5.3 KINSHIP CARE AND FOSTER CARE

5.3.1 KINSHIP CARE

Kinship Care is a public child welfare payment to the non-parental relative who is caring for a minor child. Kinship Care children are not categorically eligible for Medicaid (MA).

An non-legally responsible relative (NLRR) of children placed in their homes may be eligible for MA as a caretaker of a deprived child. This would include children receiving Kinship Care.

The client applies for Kinship Care at the Child Welfare Agency (Maximus in Milwaukee). The case is then referred to the local child support agency. When approved, a Kinship Care payment is made. S/he applies for MA through the Economic Support Agency (ESA). Run the case through regular eligibility testing for MA.

This page last updated in Release Number : 02-03
Release Date: 07/01/02
Effective Date: 07/01/02

5.3.2 Federal IV-E Foster Care

Federal financial participation is available under Title IV-E of the Social Security Act (SSA) to pay for all or part of a person's foster care or subsidized adoption. IV-E eligible children are categorically eligible for MA in the state where they reside only if placed in out of home care in a non-profit facility.

When a minor caretaker is in foster care paid by Title IV-E of the Social Security Act, any of his/her children who is with him/her must also have his/her care paid under Title IV-E. The minor caretaker's child is not eligible for MA under any other subprogram other than Title IV-E.

This page last updated in Release Number : 02-03
Release Date: 07/01/02
Effective Date: 07/01/02

5.3.3 Non IV-E Foster Care

Non IV-E foster children are automatically eligible. These cases are certified manually outside of CARES.

Wisconsin certifies non IV-E foster children living in another state when Wisconsin or one of its county/tribal agencies has legal custody of the child.

This page last updated in Release Number: 05-01
Release Date: 01/11/05
Effective Date: 01/01/05

5.3.4 MEDICAID RE-DETERMINATION

Whenever a child loses Foster Care MA eligibility, complete a separate MA eligibility re-determination before Foster Care MA is terminated, unless the child dies or leaves Wisconsin.

ESA should be notified of children leaving the Foster Care system, with eligibility information. Until the MA eligibility re-determination, the Child Welfare agency will extend MA eligibility using the Foster Care medical status code.

If there is insufficient information to redetermine MA eligibility, request needed information from the individual or family, who have a responsibility to cooperate, If they do not comply within 30 days, MA can be terminated with an adverse action notice.

This page last updated in Release Number: 02-03
Release Date: 07/01/02
Effective Date: 07/01/02

5.4 AFDC MA

5.4.1 Definition

AFDC-Medicaid is the category of Medicaid that is based on AFDC rules that were in effect on July 16, 1996. States may modify those rules as long as the state rules are less restrictive than those that were in place on July 16, 1996. Modified rules are noted in the text.

AFDC-Medicaid is always the first level of Medicaid to be tested. There are two categories: MA R (Regular) and MA U (Unemployed Parent). These two categories of MA have the lowest income limits of all the categories.

This page last updated in Release Number : 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

5.4.2 non-financial

Test the following people for AFDC-Medicaid.

1. Child (3.5.1.4) under the age of 18.
2. Dependent 18 years old (3.5.1.3).
3. Caretakers (3.5.2) of children under their care (3.5.3).
4. Pregnant women with no other children in the home, and in the 8th or 9th month of pregnancy.
5. Essential persons (3.5.4)

A pregnant woman (with no other born children in her home) may only be eligible for AFDC-MA once the pregnancy reaches the 8th month.

5.4.2.1 Deprivation

Due to changes in the unemployed parent policies communicated in Operations Memo 03-45 deprivation is no longer an eligibility criteria.

This page last updated in Release Number: 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

5.4.3 FILING UNIT

The non-financial test must include these in the filing unit:

1. The child’s natural or adoptive parents and
2. Minor blood-related or adoptive siblings.

Caretaker relatives must submit an application for all household members who are required to be in the non-financial eligibility test. They must also provide the information necessary for the agency to make a determination of eligibility.

All people in the household who are non-financially eligible form the AFDC-MA group. Count the income of the adults and minors. Deem to the group a portion of the income from adults not in the AFDC-MA group but who are legally responsible for eligible persons in the group.

5.4.3.1 Voluntary Exclusions

The following can choose to be excluded.

1. Parents and full and half siblings of a pregnant minor or minor caretaker.
2. A step-parent if there is no eligible child in common.
3. A minor who receives adoption assistance (AA).
4. A non-legally responsible relative (NLRR), their spouse and any children of theirs.
5. Stepchild who has no half-siblings of the stepparent.
6. Individual who failed the essential person test (3.5.4).
7. An alien granted temporary status under IRCA. (ops memo 97-53).
8. An NLRR child, such as a nephew.

5.4.3.2 Involuntary Exclusions

An LRR and his or spouse who are excluded from the group for any of these reasons is involuntarily excluded.

The individual is:

1. Guilty of Intentional Program Violation (IPV).
2. The spouse of a pregnant woman with no children in the home.
3. An ineligible alien.
4. A striker.
5. Not cooperating with at least one of these requirements: SSN, Child Support, or Third Party Liability.

5.4.3.3 Mandatory Exclusions

Do not include SSI and foster care recipients in the filing unit, nor count their income and assets. Do not include offender working without pay or parent in the military.

This page last updated in Release Number : 04-03
Release Date : 08/02/04
Effective Date : 08/02/04

5.4.4 FINANCIAL

5.4.4.1. Assets

There is no asset test.

5.4.4.2 Income

Use self-declared available monthly gross income when determining eligibility. If the client is applying for any other program of assistance, use the appropriate prospective budgeting technique. (4.1.6)

This page last updated in Release Number : 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

5.4.5 income Tests

Each AFDC- MA assistance group must pass three tests to be eligible. They are the gross income, net income and budget tests. See 5.4.6 for an explanation of each deduction in the income and budget tests. For manual eligibility determinations use the AFDC Individual or Group worksheets (5.4.5.5).

5.4.5.1 Gross Income Test

Add together the following items to arrive at the gross income:

1. Deemed Income (5.4.7).
2. Earned Income (4.1.5) and 5.4.8 Lump Sum.
3. Unearned Income (4.1.4) and 5.4.8 Lump Sum.

Compare the gross income to the gross income limit (5.4.9). If the family's gross income is at or below the gross income limit for their group size, begin the net income tests. If the family's gross income exceeds the gross income for their group size, the group is not eligible for AFDC-MA.

5.4.5.2 Net Income Test

This is also known as the Assistance Standard test.

Determine the total countable income by subtracting the deductions (5.4.6) that are applicable from the gross income of the household.

Compare the countable income of all group members to the Assistance Standard (5.4.11 & 5.4.12). If the total countable income is at or below the assistance standard income limit for their group size, begin the budget test. If the countable income exceeds the AS income limit for their group size, the group is not eligible for AFDC-MA.

5.4.5.3 Budget Test

This is also known as the Family Allowance. Compare the Group's Total Countable Income to the Family Allowance (5.4.13 & 5.4.14)

Apply deductions to income in the net income test for applicants, and in the budget test for recipients. The only exception is the earned income disregard. See 5.4.6.7

5.4.5.4 Student Income

In the budget test exempt all earnings of a minor or dependent 18 year old if s/he is a fulltime or part-time student.

Exception: If a minor or dependant 18 year old part-time student works more than 30 hours per week, count the earnings.

5.4.5.5 Worksheets for Manual AFDC Income Tests

AFDC INDIVIDUAL WORKSHEET

PRIMARY PERSON: SSN:

WHO & WHEN PROCESSING TOTAL				**TOTAL**
(1) Name				
(2) Payment Month & Year	___/___	___/___	___/___	
(3) Income Month	$	$	$	
INDIVIDUAL GROSS INCOME				
(4) Unearned Income	$	$	$	
(5) Plus Gross Earned Income	+	+	+	
(6) Equals Gross Income	=	=	=	
(7) Total Everyone's Line				$
INDIVIDUAL TEST INCOME				
(8) Gross Earned Income [IW (5)]	$	$	$	
(9) Minus Work Related Expenses	-	-	-	
(10) Equals Net Earned Income	=	=	=	
(11) Minus Earned Income Disregard	-	-	-	
(12) Equals	=	=	=	
(13) Minus Dependent Care	-	-	-	
(14) Equals	=	=	=	

(15) Plus Unearned Income [IW (4)]	+	+	+	
(16) Equals	=	=	=	
(17) Minus Court Order	-	-	-	
(18) Equals	=	=	=	
(19) Minus Child-in-Common	-	-	-	
(20) Equals	=	=	=	
(21) Minus Nonessential Spouse	-	-	-	
(22) Equals Individual Test Income	=	=	=	
(23) Total Everyone's Line (22)				$
INDIVIDUAL BUDGET INCOME				
(24) Net Earned Income [IW (10)]	$	$	$	
(25) Minus Student Disregard	-	-	-	
(26) Equals	=	=	=	
(27) Minus Earned Income Disregard	-	-	-	
(28) Equals	=	=	=	
(29) Minus Dependent Care [IW (13)]	-	-	-	
(30) Equals	=	=	=	
(31) Plus Earned Income [IW (4)]	+	+	+	
(32) Equals	=	=	=	
(33) Minus Court Order	-	-	-	
(34) Equals	=	=	=	
(35) Minus Child-in-Common	-	-	-	
(36) Equals	=	=	=	
(37) Minus Nonessential Spouse	-	-	-	
(38) Equals Individual Budget Income	=	=	=	
(39) Total Everyone's Line (38)				$

AFDC Group Worksheet

Primary Person: SSN:

Payment Month & Year	___/___	___/___	___/___
AFDC Group Size	#	#	#
ASSETS & DIVESTMENT TESTS			
(1) Vehicle Assets	$	$	$
(2) Plus First Vehicle's Overage	+	+	+
(3) Plus Other Nonexempt Assets	+	+	+
(4) Equal Total Assets	=	=	=
(5) Plus Divested Assets	+	+	+
(6) Equal	=	=	=
	P or F	**P or F**	**P or F**
GROSS INCOME TEST			
(7) Subgross Income [IW (7)]	$	$	$
(8) Plus Assigned & Retained CS	+	+	+
(9) Equal Group Gross Income	=	=	=
(10) Gross Income Limit Is	$	$	$
	P or F	**P or F**	**P or F**
ELIGIBILITY TEST INCOME			
(11) Eligibility Test Income [IW (23]	=	=	=
(12) Assistance Standard Is	$	$	$
	P or F	**P or F**	**P or F**
BUDGET INCOME			
(13) Group Budget Income [IW (39]	$	$	$
GRANT			
(14) Allowance Equals	$	$	$
(15) Minus Group Budget Income [GW (13)}	-	-	-
(16) Equals Grant Amount	=	=	=
(17) Grant Amount Rounded Down Is	$	$	$
BEGINNING ELIGIBILITY			

DATE			
(18) Beginning Eligibility Date	___/___/___	___/___/___	___/___/___
INITIAL PAYMENT			
(_____________ - ______________) x (____________ = _______________) (# days eligible - # days in month) x (full month's benefit = initial payment)			
(19) Full or Prorated Amount Rounded Is	$	$	$
NEXT REVIEW DUE			
(20) Month & Year	___/___	___/___	___/___
RECOUPMENT			
(21) Grant Amount is Line (17) or (19)	$	$	$
(22) Minus Monthly Recoupment Amount	-	-	-
(23) Equals Net Payment Amount	=	=	=
SUPPLEMENT			
(24) Supplemental Amount Is	$	$	$
(25) For Benefit Month(s) & Year(s)	___/___	___/___	___/___

This page last updated in Release Number : 04-03
Release Date : 08/02/04
Effective Date : 08/02/04

5.4.6 DEDUCTIONS

Each client who has earned income gets certain deductions and/or disregards.

5.4.6.1 Work Expenses

Deduct $90 for each employed person.

5.4.6.2 Dependent Care

Use the deductions found in 4.3.1.2.

5.4.6.3 Child Support

Deduct CS or maintenance paid to someone outside the AG.

5.4.6.4 CS Disregard

If CS paid to an AG member, disregard the first $50 of current CS and maintenance paid by an absent parent(s), if it is court ordered (assigned or unassigned) and paid to or for an MA group member.

If child support payments are made to the group by two or more absent parents, only disregard $50 of the total. Apply the disregard to the child support income before the child support income is added to the calculation on the worksheet.

5.4.6.5 Supporting Others

If someone in the AG is court ordered to pay support to someone outside of the group, deduct the amount that is court ordered.

5.4.6.6 Excess Self Employment Expenses

When there is more than one self-employment operation, use the losses of one to offset the profits of another.

5.4.6.7 Earned Income Disregard

Employed AFDC –MA recipients receive an income disregard for 12 months. The disregard is a standard $30 and 1/3 of the person's earned income the first 4 months.

Give the $30 and 1/3 income disregard to each person in the group who has earned income and who meets the conditions of "a" and "b", or "a" and "c" below.

1. S/he has received AFDC-Medicaid in a least 1 of the previous 4 months. During the past 12 months s/he did not exclude himself/ herself from the AFDC-Medicaid group in order to avoid receiving the $30 &1/3 for 4 consecutive months.

2. S/he never received the $30 & 1/3 for 4 consecutive months.

3. Received the $30 &1/3 for 4 consecutive months, but 12 consecutive months have gone by during which s/he did not receive AFDC-Medicaid.

4. Give the $30 disregard if the person, having received the $30 & 1/3 for 4 consecutive months, is now in the period of the 8 consecutive months immediately following the 4 consecutive months.

   Note: Do not give the $30 1/3 or the $30 disregard for the month in which the persons, during the 30 days preceding this month, and without good cause:

a. Quit their job or reduced their earned income.

b. Refused a bona fide job offer.

c. Failed to make a timely report of income received.

Here is how to calculate the $30 & 1/3 income disregard amount:

a. Deduct $30 from the person's earned income left after subtracting the $90 deduction for work expenses.
b. Multiply the remainder by 1/3.
c. Add $30 to the result.

d. Subtract the amount in “c” from the person’s earned income left after subtracting the $90 deduction for work expenses.

If the $30 & 1/3 counter does not reach 4 then the counter is reset to “0”. Restart the disregard counter if the client doesn’t receive it and AFDC-MA for four consecutive months.

5.4.6.7.1 $30 Disregard

After an AFDC-MA recipient receives 4 consecutive months of the 30 & 1/3 earned income disregard, a $30 earned income disregard becomes available for the next eight months. The availability of the disregards ends after 8 months. It does not matter if the recipient had earned income during those eight months.

This page last updated in Release Number: 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

5.4.7 DEEMING

Deeming is the allocation of income from someone who is not in the AFDC-MA group, but is a legally responsible relative (LRR) of an eligible group member of the AFDC-MA group. For Manual eligibility determinations use the AFDC deeming worksheet or the AFDC Alien deeming worksheet. (5.4.7.4.)

If a person who is not in the AFDC-MA group is legally responsible for someone in the group, it does not matter whether s/he actually gives the income to the AFDC-Medicaid group members. Consider the income available to the group and count it in the financial tests.

Do not deem from an LRR who receives Supplemental Security Income (SSI), even though s/he is not in the AFDC-Medicaid group. Instead, as you determine the group’s financial eligibility, ignore his or her presence and income.

5.4.7.1 Income Deductions for All Exclusions

1. Subtract from gross earned income. .

    a. Work related expenses of $90.
    b. Actual dependent care costs not to exceed $200 per child under the age of two or $175 per child age 2 or over or incapacitated adult.

2. Add to the result in Step 1

    a. Gross unearned income

3. Subtract from the result in Step 2

    a. Court ordered support and payments to anyone who is or could be a deduction for federal income taxes. Any such person cannot be in the household.

An additional deduction may be taken from the deemer's income. This deduction is for the needs of the LRR and/or others they are responsible for, who are not in the AFDC-MA group. The reason the LRR is excluded determines if there is an additional deduction and the amount of the deduction.

b. Actual dependent care costs not to exceed $200 per child under the age of two or $175 per child age 2 or over or incapacitated adult.

An additional deduction may be taken from the deemer's income. This deduction is for the needs of the LRR and/or others they are responsible for, who are not in the AFDC-MA group. The reason the LRR is excluded determines if there is an additional deduction and the amount of the deduction.

5.4.7.2 Involuntary Exclusions

If the LRR is involuntarily excluded due to sanctions or failure to provide information, allow no further deductions for the needs of those who were excluded. If the LRR was involuntarily excluded for any other non- financial reason, then deduct:

1. $102 for 1 LRR or spouse; or
2. $204 for both; and
3. $102 for each child of the LRR, if the child is an ineligible alien.

Deem the remainder of the income to the AFDC- Medicaid Group as unearned income.

5.4.7.3 Voluntary Excluded

Give an allowance equal to the assistance standard (5.4.12) for:

1. The included person.
2. Any spouse.
3. Their legal dependants.

Deduct the assistance standard from the net income. The assistance standard amounts are also in the CARES reference table TMST. Deem all remaining income to the AFDC-MA group as unearned income.

5.4.7.4 AFDC Deeming Worksheet for Manual Determinations

AFDC/TWO-TIER/WNW ALIEN DEEMING WORKSHEET

PRIMARY PERSON: SSN:

DEEMING GROUP			
(1) Sponsor's Group Size Is	#	#	#

ASSETS			
(2) Assets to be Deemed	$	$	$
INCOME			
(3) Gross Monthly Earned Income	$	$	$
(4) Minus $175 or 20% of Line (2)	-	-	-
(5) Equals Net Earned Income	=	=	=
(6) Plus Unearned Income	+	+	+
(7) Equals	=	=	=
(8) Minus Assistance Standard	-	-	-
(9) Equals	=	=	=
(10) Minus Money Out of Household	-	-	-
(11) Equals Income to be Deemed	=	=	=

This page last updated in Release Number : 04-03
Release Date : 08/02/04
Effective Date : 08/02/04

5.4.8 Lump-Sum Income

A lump-sum payment is (1) a nonrecurring payment or accumulation of individual payments, (2) paid in one lump sum to any AFDC-MA group member. The payment can be either unearned or earned income. However, do not include payments that are included in farm or self- employment income.

An group member may be a payee for administrative reasons, but not the payment's owner or beneficiary. If so, do not count the payment as income to the group.

Lump –sum sources include:

1. Social Security, veterans, unemployment compensation benefits and child support refunds.

2. Union settlements and compensatory time payments (earned).

3. Windfall payments like bingo and lottery winnings, personal injury awards, cash inheritance, and nonexempt gifts (unearned).

   a. These are not windfall payments: (1) assets awarded in a divorce settlement, and (2) a vested interest (the person owns it even before s/he receives it) retirement fund distribution. They are assets not income.

   b. Disregard any amount earmarked and used for the purpose it was paid. This includes back medical bills from an accident or injury, funeral and cemetery costs, and replacement or repairs.

      Disregard any amount earmarked for medical services that can be provided only at a future date. First get a signed agreement specifying:

- Source and amount of the settlement.
- Purpose for which it is earmarked.
- That it held in its own account.
- Agreement to and understanding that if any amount of the settlement is used for a purpose not earmarked, the total settlement is counted as a lump-sum.

Budget lump-sum payments as follows:

1. Include with other income the lump-sum payment as unearned or earned income received in the same month. Use the Financial Section to determine Group Budget Income.

2. Divide Group Budget Income by the Assistance Standard for this size group. The result is the number of months the group is ineligible.

3. Budget any remainder in step 2 in the 1st month after the period of ineligibility.

Discontinue AFDC-MA in the next possible month immediately after the month in which the person received the lump sum. That date is the beginning of the period of the ineligibility.

Example 1: For a lump sum received before May cutoff, the next possible payment is June.

Using the current amount, recalculate (steps 1-3, above) the lump-sum obligation as of the date of change when:

1. The former group's grant would have increased due to a statutory increase in the Assistance Standard and Family Allowance.

2. The lump-sum income or a portion of it becomes unavailable to the former group for a reason beyond the group's control. Reasons include:

   a. The lump-sum was used because of an immediate threat to the health, safety, or welfare of the former group.

   b. Loss or theft of income.

   c. The person who received it leaves the group.

3. A former group member incurs and pays all or some medical expenses during the period of ineligibility. The expenses must equal or exceed any balance remaining after calculating the period of ineligibility (step 3, above) or they must be ignored.

> Example 2: Client receives a $2000 lump-sum. You calculate a 3 month period of ineligibility with a $419 left to budget in month 4.
>
> 1. The client reports in month 2 that s/he incurred and paid $1200 in medical bills. You can use the medical bills to recalculate the period of ineligibility because they exceed $419. Recalculate using $800 as the lump-sum amount.
>
> In month 3 the client reports s/he has incurred and paid $200 is less than the $419 , so it has no affect. The period of ineligibility remains the same. Budget $419 in month 4.

If the size of the group increases during the period of ineligibility of the person added to the AFDC group separately.

This page last updated in Release Number : 04-03
Release Date : 08/02/04
Effective Date : 08/02/04

5.4.9 gross income limit

(See 8.1.3 for your area.)

Area 1	Group Size	Area 2
$ 576	1	$ 557
1,018	2	987
1,197	3	1,159
1,429	4	1,386
1,640	5	1,593
1,773	6	1,719
1,919	7	1,863
2,034	8	1,976
2,130	9	2,067
2,182	10	2,115
2,228	11	2,161
2,274	12	2,208
Add $46 for each person for groups larger than 12		

This page last updated in Release Number: 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

5.4.10 Gross income limit and pregnancy allowance

(See 8.1.3 for your area.)

Area 1	Group Size	Area 2
$ 707	1	$ 689
1,149	2	1,118
1,329	3	1,290
1,560	4	1,517
1,771	5	1,725
1,904	6	1,850
2,050	7	1,995
2,165	8	2,108
2,261	9	2,198
2,313	10	2,246
2,359	11	2,293
2,405	12	2,339
Add $131 for each added pregnant woman in the group. Add $46 for each person for groups larger than 12.		

This page last updated in Release Number: 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

5.4.11 Assistance Standard

(See 8.1.3 for your area.)

Area 1	Group Size	Area 2
$ 311	1	$ 301
550	2	523
647	3	626
772	4	749
886	5	861
958	6	929
1,037	7	1,007
1,099	8	1,068
1,151	9	1,117
1,179	10	1,143
1,204	11	1,168
1,229	12	1,193
Add $25 for each person for groups larger than 12		

This page last updated in Release Number: 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

5.4.12 assistance standard and pregnancy allowance

(See 8.1.3 for your area.)

Area 1	Group Size	Area 2
$ 382	1	$ 372
621	2	604
718	3	697
843	4	820
957	5	932
1,029	6	1,000
1,108	7	1,078
1,170	8	1,139
1,222	9	1,188
1,250	10	1,214
1,275	11	1,239
1,300	12	1,264
Add $71 for each pregnant woman in the group. Add $25 for each person for groups larger than 12.		

This page last updated in Release Number: 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

5.4.13 family allowance

(See 8.1.3 for your area.)

Area 1	Group Size	Area 2
$248.00	1	$240.80
440.00	2	426.40
517.60	3	500.80
617.60	4	599.20
707.80	5	688.80
766.40	6	743.20
829.60	7	805.60
879.20	8	854.40
920.80	9	893.60
943.20	10	914.40
963.20	11	934.40
983.20	12	954.40
Add $20 for each person for groups larger than 12		

This page last updated in Release Number: 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

5.4.14 family allowance and pregnancy allowance

(See 8.1.3 for your area.)

Area 1	Group Size	Area 2
$ 305.60	1	$ 297.60
496.80	2	483.20
574.40	3	557.60
674.40	4	656.00
765.60	5	745.60
823.20	6	800.00
886.40	7	862.40
936.00	8	911.20
977.60	9	950.40
1,000.00	10	971.20
1,020.00	11	991.20
1,040.00	12	1,011.20
Add $56.80 for each pregnant woman in the group. Add $20 for each person for groups larger than 12.		

This page last updated in Release Number: 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

5.5 AFDC RELATED MA

5.5.1 DEFINITION

AFDC-Related Medicaid (MA) is the category of MA that is based on AFDC rules that were in effect as of July 16,1996.

AFDC-Related MA is the 2nd level of MA you test. There are two categories: MAOR (Regular) and MAOU (Unemployed Parent).

AFDC-Related MA had almost the same eligibility requirements as AFDC-MA. If something is not noted here, see 5.4 for the requirements.

This page last updated in Release Number : 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

5.5.2 NON-FINANCIAL

Household members who meet all general non-financial requirements (1.1.2) are AFDC-related if s/he is a:

1. Child less than 19 years old,
2. Caretaker of a child (3.5.2), or
3. Pregnant woman, (medically verified) or,
4. Under 21 years old and residing in a institution for mental disease (IMD) (5.8.1.1)
5. 21 years old, and residing in an institution for mental disease, and residing there since at least age 20.
6. Essential person.
7. Less than 19 years old and residing in a licensed foster home, or licensed child caring institution.

5.5.2.1 MA Group

The MA group includes those who requested MA, who were tested and found non-financially eligible.

5.5.2.1.1 Voluntary Exclusion

Children and NLRR can be voluntarily excluded from the AFDC- related MA AG.

5.5.2.1.2 Involuntary Exclusions

A legally responsible relative (LRR) and his or her spouse are involuntarily excluded from the group if:

1. S/he is guilty of Intentional Program Violation (IPV).
2. He is the spouse of a pregnant woman with no children in the home.

3. S/he is an eligible alien.
4. S/he is on strike.
5. S/he didn't cooperate with at least one of these requirements: SSN, Child Support, or Third Party Liability.

Involuntary exclusions and deeming follow AFDC-MA policy (5.4.7.1).

5.5.2.2 Fiscal Test Group (FTG)

The FTG includes all household members who are non- financially eligible or who have legal responsibility for anyone within the MA group.

This page last updated in Release Number : 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

5.5.3 FINANCIAL

5.5.3.1 Assets

There is no asset test.

5.5.3.2 Income Tests

Determine the total budgetable income by subtracting the deductions listed in 5.5.4 from the gross income.

Compare the budgetable income to the categorically needy income limit (8.1.4). (If a pregnant woman is in the group, increase the group size by 1 for each fetus that she is carrying.)

1. If the group's income is equal to or less than that limit, the group is eligible for categorically needy MA.

2. If the group's income is greater than the categorically needy limit, the group is medically needy.

   a. If the group fails the medically needy income test, see if the caretaker meets FFU testing criteria (4.8). If s/he does, test for FFU. If s/he fails that, the Medically Needy caretaker is not eligible for AFDC-related MA. Test the rest of the group for MA deductible.

      If the caretaker is EBD-related, test the caretaker and spouse for EBD-Related MA (Chapter 1.1)

   b. If in the group there is a pregnant woman or a child under 19, test for Healthy Start (5.2).

c. If the income is not greater than the medically needy income limit, the children are medically needy eligible.

3. If the group's income is greater than the medically needy limit, and there is a child under 19 who is blind or disabled (5.2)., test the child in the Blind or Disabled Minor 1.1.3.1.2

If there is no blind or disabled child, determine the MA deductible for the fiscal test group (4.9).

5.5.3.3 Lump Sums

Lump sums are assets. This differs from the AFDC-MA (5.4)

This page last updated in Release Number : 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

5.5.4 DEDUCTIONS

Determine the total countable income of the group members by subtracting any of the following deductions that are applicable:

Work-Related Expense (5.4.6.1)
Child Support Disregard (5.4.6.3)
Child Support Paid. (5.4.6.5)
Dependant Care (5.4.6.2)
Excess Self-Employment Expenses (5.4.6.6)
Supporting Others (5.4.6.5).
Apply any other Family MA income disregards (4.1).

This page last updated in Release Number: 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

5.5.5 EXTENSIONS

There are no extensions for AFDC-Related MA assistance groups, other than the pregnancy extension (5.6.5).

This page last updated in Release Number: 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

5.6 AFDC MA EXTENSIONS

5.6.1 INTRODUCTION

A Medicaid extension is a period of Medicaid eligibility given to an AFDC-Medicaid recipient beyond the time when AFDC-Medicaid closes.

The Medicaid extension lasts 12 months. In some instances, where child support money is involved, the extension may last only 4 months (5.6.6.1).

Extensions belong to individuals, not to groups. An individual whose AFDC-Medicaid closes for 1 or more of the extension reasons (5.6.3) receives an extension. Give him/her the extension even if the rest of the AFDC-Medicaid AG doesn't close.

This page last updated in Release Number: 99-01
Release Date: 01-01-99
Effective Date:01-01-99

5.6.2. REQUIREMENTS

To receive a Medicaid extension, a person must meet 2 requirements:

1. His/her AFDC-Medicaid closure must be due solely to 1 or more of the extension reasons listed in (5.6.3).

2. S/he must be an AFDC-Medicaid recipient at the time AFDC-Medicaid closes (5.6.4).

This page last updated in Release Number : 01-99
Release Date: 01/01/99
Effective Date: 01/01/99

5.6.3 EXTENSION REASONS

For a 12 month Medicaid extension, the AFDC-Medicaid closure must be due solely to 1 or more of the following reasons:

1. The $30+1/3 disregard ended.
2. The $30 disregard ended.
3. Increased hours of employment.
4. Increased earnings.
5. Increased earnings along with other income (changed or unchanged).

At least 1 member of the AG must have:

Received AFDC-Medicaid for at least 3 of the 6 months immediately preceding the month in which AFDC-Medicaid was discontinued.

At least 1 of the 3 months of AFDC-Medicaid benefits must be Wisconsin AFDC-Medicaid benefits.

Example: Earl moved his family from Arkansas to Wisconsin in April. The family applied for AFDC-Medicaid in Wisconsin and became eligible for Wisconsin AFDC-Medicaid on April 16. One month afterward, Earl got a job. AFDC-Medicaid closed because of his increased earnings. The family is eligible for a 12 month extension because 2 months of AFDC-Medicaid in Arkansas in the last 6 months count toward the total of 3 months of AFDC-Medicaid in the last 6 months.

Closure reasons 3, 4, & 5 require that at least one member of the AG be employed throughout the 12 month extension. If s/he loses employment, end the extension, unless the loss of employment is temporary. Temporary loss of employment occurs for reasons such as equipment break-downs, slack periods, weather restrictions, fire, and retooling of work areas. The worker is laid off for a definite period of time, or for an unspecified period, but the employer states s/he will be called back to work eventually.

5.6.3.1 Sole Reason

An AFDC-Medicaid AG receives a Medicaid extension when the sole AFDC-Medicaid closure reason is 1 or more of the extension reasons listed (5.6.3).

No other closure reason can accompany the extension reason. If an extension reason is accompanied by a nonfinancial closure reason or by an excess assets closure reason, there is no extension.

Example 1: Marvin was an AFDC-Medicaid recipient. On July 15 he reported to his ESS that he had received $5,000 from the sale of property which he had owned jointly with his uncle. He also reported that he had recently obtained a job and was now working 40 hours a week. When Marvin's AFDC-Medicaid closes, he will not receive an extension because the increased hours of employment is not the sole reason for the AFDC-Medicaid closure.

At the end of the month, before the effective date of closure, if all closure reasons have disappeared except the extension reason, give the extension.

Example 2: In the last week of July, Marvin reported to his ESS that he had purchased a computer and other personal items, and had less than $900 left from the original $5000. Marvin can now receive an extension because, before the effective date of his AFDC-Medicaid closure, the only closure reasons remaining are the increased hours of employment and increased earned income.

This page last updated in Release Number : 01-99
Release Date: 01/01/99
Effective Date: 01/01/99

5.6.4 MUST BE A RECIPIENT

To receive an extension, the person must be an AFDC-Medicaid recipient at the time the extension reason occurs.

Example 1: Denny, an absent parent, returns to the household. On a retest of the AFDC-Medicaid AG, Denny's hours of employment and earned income close AFDC-Medicaid. The recipients at the time of closure receive a 12-month Medicaid extension. Denny does not because he was not an AFDC-Medicaid recipient. The extension continues as long as Denny, or another member of the last tested AFDC-Medicaid AG, is employed.

Example 2: Maurice was under an AFDC-Medicaid sanction. When the sanction ended, the new AFDC-Medicaid AG, with Maurice as a member, was tested. It failed because of Maurice's increased hours of employment and increased earned income. Maurice does not receive the extension because he was not an AFDC-Medicaid recipient at the time AFDC-Medicaid closed.

Example 3: George and his 2 children are AFDC-Medicaid recipients. George's oldest child turns age 19. George's earned income and assigned child support are now too high for an AG of 2. AFDC-Medicaid closes. George and both children receive the extension because all were AFDC-Medicaid recipients at the time AFDC-Medicaid closed.

5.6.4.1 SSI Exception

A person who was eligible for both AFDC-Medicaid and SSI and who chose to receive SSI benefits instead of AFDC-Medicaid benefits, may be eligible for a Medicaid extension if s/he loses SSI.

Example 1: Mary is eligible for AFDC-Medicaid because she is the caretaker of 2 deprived children. She is eligible also for SSI because of a disability . She chose to receive SSI instead of AFDC-Medicaid. Her 2 children are AFDC-Medicaid recipients. Mary got a job. Her earnings put her above the SSI income limit. She then joined her children's AFDC-Medicaid AG. Her earned income caused AFDC-Medicaid to close. Both Mary and her 2 children are eligible for a Medicaid extension.

This page last updated in Release Number : 00-04
Release Date :07-01-00
Effective Date : 07-01-00

5.6.5 EXTENSIONS FOR PREGNANCY AGS

A pregnant woman who is eligible for Medicaid/Healthy Start stays eligible for:

1. The balance of the pregnancy, and

2. An additional 60 days after the last day of pregnancy through the end of the month in which the 60th day occurs.

The decision on her eligibility need not be made prior to termination of pregnancy, but the application **must** be before. A presumptive eligibility application does not meet this application test.

This page last updated in Release Number : 00-04
Release Date: 07-01-00
Effective Date: 07/01/00

5.6.6 CHILD SUPPORT INCOME

If an AFDC-Medicaid recipient becomes ineligible for AFDC-Medicaid solely for excess income, and all or part of the excess income consists of child support collections, grant an extension of either 4 or 12 months.

5.6.6.1 Four Months

The 4 month child support extension applies only if at least 1 member of the former AFDC-Medicaid group has received AFDC-Medicaid for at least 3 of the 6 months immediately preceding the month in which AFDC-Medicaid was discontinued.

Give the four-month child support extension when all three of the following exist:

1. Excess income.
2. Child support income (changed or unchanged).
3. No increase in earned income.

5.6.6.2 Twelve Months

Give a twelve-month extension to an AG with:

1. Increased earned income and child support collections that don't increase, **or**

2. Increased earned income and increased child support collections.

This page last updated in Release Number : 00-04
Release Date: 07-01-00
Effective Date: 07/01/00

5.6.7 MULTIPLE EXTENSIONS

During an extension, a group or individual may become eligible for AFDC-Medicaid and then, for one of the reasons listed (5.6.2) become ineligible again and earn another extension. When more than one extension applies at the same time, choose the extension which gives the longest coverage, and cancel the other.

Example 1: A former AFDC-Medicaid group with a twelve-month extension comes back on AFDC-Medicaid. The extension continues to run while the group is on AFDC-Medicaid. In the tenth month of the twelve-month extension the group goes off AFDC-Medicaid again and qualifies for a four-month child support extension. Apply the new four-month extension because it gives the longest coverage. Cancel the remaining two months of the twelve-month extension.

Determine what extensions each person in the AFDC-Medicaid group has, and apply any new extension accordingly.

Example 2: Two persons in the current AFDC-Medicaid group earned a twelve-month extension from membership in a previous group. The current group now goes off AFDC-Medicaid and earns a four-month child support month extension. The two persons with twelve-month extensions are entitled to retain them if this results in a longer period of Medicaid coverage for them than the new four-month extension would.

This page last updated in Release Number: 02-01
Release Date: 01-01-02
Effective Date: 01-01-02

5.6.8 INTER-AGENCY TRANSFERS

When a person who is on a Medicaid extension moves to another county or tribal area, transfer the case to the new agency. The agency that the client reports the move to must collect information about the changes, for example, the new address. If the agency does not have sufficient information about the changed circumstances, it must request information from the client, according to the Medicaid verification policy (1.2).

CARES will automatically set a review date for one month after the transfer. Correct the review date in CARES, so that it is the end of certification period. Run eligibility in CARES.

Example: Jules is on an extension that expires March 31, 2001. He moves from Waupaca County to Vilas County in January 2001. Waupaca County must transfer Jules' case to Vilas County. Vilas County corrects Jules' review date to March 31, 2001.

This page last updated in Release Number : 04-01
Release Date : 02-27-04
Effective Date : 02-27-04

5.6.9 LOSING AN EXTENSION

An extension recipient loses an extension if one or more of following happens:

1. S/he fails to cooperate in providing third party health insurance coverage (TPL). Minors and dependent 18 year olds are exempt from any penalty for not cooperating with this requirement.

2. S/he fails to cooperate with medical support liability requirements (6.3.1 and (3.3.1). Pregnant women, minors, and dependent 18 year olds are exempt from any penalty for not cooperating with this requirement.

3. S/he loses employment when the extension requires that someone in the group remain employed.

If a condition necessary for an extension is lost, the extension is not regained solely by recovering the lost condition.

Example: A group has an extension that requires someone in the group to remain employed. Since no one in the group is currently employed, the extension is lost. The group does not regain the extension if someone goes back to work.

5.6.9.1 Leaving Wisconsin

If a Wisconsin extension recipient moves out of state, s/he loses the extension. S/he can regain the extension if s/he returns and becomes a Wisconsin resident again.

Example 1: Earl, a Wisconsin resident, received a 12-month extension beginning January 1, 1999. He moved out of state, thus losing his extension. On May1, 1999, he moved back to Wisconsin and became a Wisconsin resident again. He regained the extension at the time he moved back to Wisconsin and became a Wisconsin resident.

If the time period of the extension expires while the person is out of state, s/he does not regain the extension.

Example 2: Gloria, a Wisconsin resident received a 12-month extension beginning January 1, 1999. She moved out of state, thus losing her extension. In February 2000, she moved back to Wisconsin and became a Wisconsin resident again. She does not regain the extension because the time period has expired.

This page last updated in Release Number : 04-01
Release Date: 02-27-04
Effective Date: 02-27-04

5.7 BADGERCARE

5.7.1 BADGERCARE (BC) DEFINITIONS

5.7.1.1 BadgerCare

BadgerCare (BC) is an expansion of Wisconsin's MA program.

All general MA non-financial requirements (1.1.2) apply to BC in addition to those items listed in (5.7.3) Explain the BC program to each household that includes a potential BC client, and offer them an opportunity to apply for BC. Potential BC clients are:

1. Children under age 19. For BC purposes, a child is defined as being under age 19. Marital status does not affect an individual's status as a child.

2. Parents living with children under age 19.

3. Spouses living with parents of children under the age of 19.

If a client fails all other full-benefit MA subprograms (7.1.2), test them for BC.

They will be eligible for BC if they:

1. Meet BC non-financial (5.7.3) and financial (5.7.4) tests.

2. Are not eligible for any other full-benefit MA subprograms.

   Full-benefit MA eligibility does not include those subprograms listed in 7.1.3

5.7.1.2 BC Applicants

BC applicants are those who have not been eligible in the current or previous month for BC.

5.7.1.3 BC Recipients

BC recipients are those who are eligible for and receiving BC in the current or previous month.

This page last updated in Release Number : 05-01
Release Date: 01/11/05
Effective Date: 01/11/05

5.7.2 Application

Eligibility goes back to the first of the month of application in which all eligibility requirements were met. There is no three-month backdate period for BC.

This page last updated in Release Number : 02-03
Release Date: 07/01/02
Effective Date: 07/01/02

5.7.3 NONFINANCIAL REQUIREMENTS

The following are BC specific non-financial requirements:

1. Meet general MA non-financial requirements (1.1.2).

2. A child under age 19, parents living with children under age 19, or a spouse living with parents of children under the age of 19.

3. Do not have health insurance coverage (5.7.3.4) now or in the three calendar months prior to the BC request.

4. Do not have access to health insurance coverage (5.7.3.5) now or in the past 18 months.

5. Pay a premium if the family income exceeds 150% of the FPL (8.1.11).

5.7.3.1 Deprivation

There is no requirement that a parent be the caretaker of a deprived child. Do not deny BC for failure to furnish or verify information necessary to establish deprivation.

5.7.3.2 Joint Custody

When the natural or adoptive parents of a child do not live together, and have joint custody, either parent can apply for BC. If both parents are applying, only one parent can be determined eligible at a time. See 3.5.3.2 if there is any question about who is the primary person, including if there is an arrangement where the minor spends equal time in each household.

5.7.3.3 Health Insurance Premium Payment (HIPP)

Cooperation with HIPP is a BC non-financial eligibility requirement (6.3.7).

5.7.3.4 Insurance Coverage

A person is ineligible for BC, when s/he:

1. Is covered or has been covered in the three calendar months prior to the BC request by any health insurance plan, and

2. The health insurance plan meets the standards of a Health Insurance Portability and Accountability Act (HIPAA) standard plan (6.3.2).

The policyholder does not need to live in the home. The plan can be individual or family coverage. The person or employer's share of the premium has no affect. Someone with coverage in a location other than where they are living is still insured. It does not matter if it is another county or another state.

Coverage includes employer based and any other health insurance coverage. It does not include MA, Medicare Managed Care (aka Medicare Choice Plus), Medicare, Medicare Supplemental policies, HIRSP, WisconCare (WisconCare was discontinued effective 7/25/03 by the 2003/2005 Budget Bill) , General Relief, General Assistance, or Family Health Plan coverage. The Family Health Plan is a government sponsored safety net coverage run by Marshfield clinics.

5.7.3.4.1 Self-Employed

Consider self-employed people, including farmers, as covered by health insurance and if the:

1. Individual purchased a plan that covers him or herself, or

2. The business is incorporated and s/he is an employee of the corporation, and has health insurance through the corporation.

Good Cause - Good cause exists if the owner of any self- employment enterprise lost health insurance in the previous three months prior to the eligibility determination if:

1. The operation provides health insurance coverage to the individual, **and**

2. That operation drops health insurance coverage for **all** employees of the operation, **and**

3. The farm or self-employment operation lists the health insurance costs as a business expense/loss on their tax forms. The expense/loss must be listed on either the self-employment tax forms or self employment health insurance deduction line on the IRS 1040.

This means that the self-employed person, who meets all the above criteria and who drops his/her health insurance coverage in the month prior to application for BC, does not have to wait three months before eligibility can begin.

5.7.3.4.2 Coverage Process

Collect insurance coverage information from the client and through CARES. EDS verifies insurance information.

If the client does not know if the non-custodial parent has a health insurance plan that provides coverage for anyone in the household, assume they do not have one.

If the client does not know if s/he or someone other than the non-custodial parent has health insurance, ask for the information and consider it questionable until s/he provides the information.

CARES will send coverage information to EDS, only if the insurance information is complete in CARES. EDS will verify insurance coverage information. If EDS verifies insurance coverage exists, and sends that information to CARES. You will receive an alert if EDS finds that there is verified coverage through a HIPAA standard plan (6.3.2). Review the insurance information for accuracy, and in cases involving past coverage, check with the clients as to whether there was good cause for losing coverage. BC eligibility will end at the end of the month following adverse action for those clients with HIPAA insurance coverage currently in effect or in the three prior calendar months.

5.7.3.4.3 Coverage Good Cause Reason

If a person has good cause for dropping or losing his/her employer provided insurance coverage in the previous three months, s/he may be eligible. Good cause reasons are:

1. Loss of employment, other than a voluntary termination.

2. Loss of employment due to the employee's incapacitation.

3. Change to a new employer that does not offer coverage.

4. End of COBRA continuation.

5. Coverage ends due to death, divorce or age.

6. Coverage ends due to reduced (voluntary or involuntary) hours of employment.

7. Discontinuation of health benefits to all employees by the client's employer. See 5.7.3.4.1 for self-employed.

If you have an unusual situation where coverage ended in the last three months for a reason beyond the control of the family, contact the CARES Call Center. Medicaid staff will determine if good cause exists and the Call Center will notify you. It is not good cause if a person drops coverage because of the cost.

Clients who have lost their insurance coverage due to involuntary loss of employment, and meet all other eligibility requirements, are eligible for BC. Begin his/her BC eligibility the day after the last day of the insurance coverage or the application date, whichever is later.

If s/he opts to take COBRA coverage, do not begin his/her BC eligibility until the COBRA coverage has ended because it has reached the 18th month. Do not begin BC eligibility the day after COBRA coverage has ended if the coverage ended because of voluntary termination or the client did not pay the premiums.

5.7.3.5 Insurance Access

Clients are ineligible for BC if they have access to health insurance through a household member's employer. EDS verifies insurance access using the current employer's information from CARES. Insurance access means a family member living in the household is employed:

1. And can sign up for an employer-subsidized **family** health care plan which meets the HIPAA standard plan (6.3.2) definition, and for which the **employer pays 80% or more** of the cost of the premium for the plan. Consider all members of the household that could be covered by that employer's policy to have access; **or**

2. By a unit of state government and can sign up for the State's health care plan which meets the HIPAA standard plan (6.3.2) definition. Consider those who could be covered by the State's health care plan to have access. It does not matter if the plan is **family or individual**, or what premium amount that state government would pay.

Access includes the ability to sign up and be covered in the current month. It also includes if s/he had the ability to sign up and be covered in any or all of the 18 months prior to the application or redetermination of BC eligibility.

If the client had access any time in the past 18 months, those who had access are ineligible for 18 months. There are three different situations to consider when determining whether access exists.

BC clients are not exempt from being required to sign up with an employers' health plan when members of the household receive MA or have other insurance coverage.

5.7.3.5.1 Current Access

If a family could sign up this month and be covered this month (employer pays 80% or more), then all members of the family who could be covered are ineligible for BC.

Start of Ineligibility Period: Start the ineligibility period after giving timely notice.

Example: Tom applies September 10, 2001. EDS discovers in early October that Tom can enroll his family under his employer's health plan at any time and coverage would start immediately. He is given timely notice and closes at the end of October. The ineligibility period starts November 2001.

5.7.3.5.2 Past Access

If a family could have signed up (or been signed up for) and been covered through employer provided family coverage (at 80% or more) through the current employer in the past 18 months, they are ineligible.

Do not deny the group's eligibility based on access if anyone in the household was covered by MA (but not BC) or another health insurance plan at the time the group could have been enrolled in the employer's plan.

Start of Ineligibility Period: If a family could have signed up for family coverage through an employer group health plan, the members with access remain ineligible for 18 months from the month coverage could have started. The ineligibility period may cover a period when the client received BC. See the second example.

Example 1: Jim applies for BC in July 2001. In October 2000, Jim's employer had an open enrollment health insurance period with coverage starting in January 2001. He did not enroll. Jim's children were eligible for MA in October, so he remains eligible.

Example 2: Kim applies for BC in November 2000, and is approved. No one else in her household had MA eligibility or insurance coverage during the last three months. EDS finds in February 2001, Kim could have signed up with her employer's health plan in February 2000, and coverage would have been available March 2000. She did not sign up and will not get another chance to sign up until February 2002. The ineligibility period starts March 1, 2000 for Kim and the children. Do not consider the BC she received from November to February to be incorrect benefits.

Example 3: The same circumstances as the above, except the children were covered by health insurance in February 2000. The children's coverage allows Kim to be eligible.

Note: If Kim is still on BC next February, she will be required to sign up with the employer's plan, even if the children are on MA.

5.7.3.5.3 Future Access

If the family can sign up for coverage in which the employer pays 80% or more, but it does not start until a later date, s/he must sign up for the coverage. EDS monitors this and notifies you via CARES. If s/he does sign up, continue BC eligibility until the end of the month in which insurance coverage starts. Clients receive the full month to avoid gaps in coverage if a new policy starts after the first of the month.

Even if a client does not sign up for coverage that starts at a later date, continue BC eligibility until the end of the month in which insurance coverage could start.

Start of Ineligibility Period: Start the ineligibility period the month after access to coverage.

Example: Bob's employer offers health insurance in January. The coverage will not start until March 1st. Bob does not sign up. Bob's family remains BC eligible through March 31st. The ineligibility period starts April 1st.

5.7.3.5.4 Self-Employment

For self-employment operations in which the owner/operator is applying for BC, do not consider the coverage the operation provided in the past, or could provide, when determining if there is past access.

5.7.3.5.5 Access Process

Insurance access will be determined only by EDS. You will collect insurance access information from the client and through CARES. However, do not verify insurance access information for BC. Accept the client's statements in determining initial BC eligibility. Do not verify information concerning who could be covered in the household, or whether the coverage meets the HIPAA standards (6.3.2).

Persons who say they have access to employer subsidized-health plans remain eligible for BC until EDS verifies who in the household has access. EDS obtains any insurance information that is needed from the employer directly.

Ask the client if s/he has access to a group health plan. If s/he does, CARES sends that information to EDS upon confirmation. EDS then sends an Employer Verification of Insurance Coverage (EVIC) form to the employer who completes it and gives it back to EDS. If a family member does have insurance access, s/he will become ineligible. The case runs through adverse action and closes at the end of the month.

5.7.3.5.6 Access Good Cause Reasons

Good cause reasons for not having insurance access are:

1. Loss of employment.
2. Change to a new employer that does not offer access.
3. Access ends due to death, divorce or age.
4. Reduced hours (voluntary or involuntary) lead to loss of insurance access.

For clients who have lost their insurance access due to involuntary loss of employment, and meet all other eligibility requirements, begin his/her BC eligibility the day after the last day of the insurance access. A client who declined to take COBRA coverage at the time of the involuntary loss of employment did not have access to insurance.

This page last updated in Release Number : 05-01
Release Date: 01/11/05
Effective Date: 01/11/05

5.7.4 Test Group

The BC test group is the group of household members that is tested for BC eligibility. Include the following in the BC test group:

1. A child under age 19 who is the primary person or who has a qualifying relationship with the primary person, his/her spouse and any non-marital co-parent (NMCP).

2. The spouse of the primary person (includes a stepparent).

3. A co-parent with the primary person of a child living in the house (includes a NMCP).

4. The spouse of a minor parent.

5. A co-parent with a minor parent of a child living in the household.

Note: a stepparent living with a stepchild(ren) (biological parent not in the household) who has no other child(ren) of his/her own in the household is **not** eligible.

This page last updated in Release Number : 03-03
Release Date: 09/22/03
Effective Date: 09/22/03

5.7.5 Fiscal Test Group

Take those in the test group who are non-financially eligible to the fiscal test. The fiscal test group (FTG) includes all:

1. Household members who are non-financially eligible, **and**
2. Test children (5.7.5.3), **and**
3. Ineligible household members who are legally responsible for all person(s) listed in #1, except for those who are only legally responsible for test children.

Example: Cheryl and Eric are not married, and have a child together. Cheryl is requesting MA and BC for herself and their child, Alex. Eric is not requesting BC. Alex is found eligible for Healthy Start. In building the FTG, Alex is a test child because he is receiving MA. Eric is not part of the FTG, because he is only legally responsible for a test child in the FTG.

Build the BC FTG around the primary person. If the only potentially eligible BC child left is a non-legally responsible relative (NLRR) child, build a separate group around the NLRR child. Take the FTG to the income tests.

5.7.5.1 SSI Recipients

Do not include SSI recipients in the BC test or FTG. Do not count their income.

5.7.5.2 MA Eligible Adults

Include the MA eligible adult in the BC FTG if s/he is legally responsible for a BC test group member. Include his/her income.

Example: Michelle is pregnant and receiving Healthy Start. She is requesting BC for her son, Steve. Michelle's income would be included in the eligibility test for BC for Steve, and she would be included in his BC FTG.

5.7.5.3 Test Children

Test children include the minor children that are ineligible for BC solely because of one of the following or any combination of the following:

1. Are MA eligible, **or**
2. Have insurance access, **or**
3. Have insurance coverage, **or**
4. Are ineligible for BC solely because they receive adoption assistance.
5. Have an unmet deductible

Do not count the income of the test children, but include these minor children in the FTG as test children. When a child is on MA (other than SSI) in another case s/he can still be considered a test child in their parent's BC case if they are living in the home with them.

5.7.5.4 Ineligible BC Adults

Adults Include any ineligible adult who has legal responsibility for someone who passed the non-financial test. Count their income. The exception is SSI recipients.

5.7.5.5 Ineligible BC Children

Do not include ineligible BC children, except for test children (5.7.5.3), in the FTG. Exclude an ineligible child's income.

Example: Charlene is requesting MA and BC for three of her children. She is not requesting MA or BC for one of her children, Eric. Eric's income should not be counted when determining BC eligibility for the other members of the family, and he is not included in the BC FTG.

5.7.5.6 Adults with Health Insurance

Include the adults (legally responsible for a BC test group Insurance member) with health insurance in the fiscal test group.

5.7.5.7 Exclusions

Anyone may be excluded from BC. Include the income of an excluded adult who is legally responsible for someone in the BC fiscal test group, except test children. If a child is excluded, do not count his/her income or include them in the BC FTG, unless the child is a parent of a child in the home who is eligible for BC. Excluded children include those who are non-financially ineligible for BC for a reason other than access or coverage. Examples are those who are not providing a SSN and SSI recipients.

5.7.5.8 Fetus

Increase the FTG size by one for each fetus a pregnant woman is carrying.

5.7.5.9 Temporary Absence

If the child is temporarily absent, and the parents have no other children in the home, the parents are ineligible for BC. A child can be temporarily absent and still be eligible for BC.

This page last updated in Release Number : 04-01
Release Date: 02/27/04
Effective Date: 02/27/04

5.7.6 Financial

5.7.6.1 Assets

There is no asset test.

5.7.6.2 Income

Use self-declared monthly gross income when determining eligibility for a client who is **only** applying for MA. If the client is applying for any other program of assistance, use the appropriate prospective budgeting technique (4.1.6.1). Determine the total family income by subtracting any of the following deductions that are applicable from the gross income of the household:

1. $90 Work-Related Expense (4.1.3.5).
2. Child Support Disregard (4.1.2.21).
3. Dependent Care (4.3.1.2).
4. Apply any other Family MA income disregards (4.1).

5.7.6.2.1 BC Applicant

A BC applicant AG's income after deductions cannot exceed 185% of the FPL (8.1.6).

5.7.6.2.2 BC Recipient

The income of an AG in which at least one member was a BC recipient cannot exceed 200% of the FPL (8.1.6).

5.7.6.2.3 Migrants

See 5.11.8.2.

This page last updated in Release Number : 02-04
Release Date: 10/01/03
Effective Date: 10/01/03

5.7.7 Deductible Choice

When a person is determined eligible for a deductible and BC in the same month, s/he must choose between the two. Compare the total monthly BC premiums for the six-month period with the deductible for the six months. Explain the dollar amount differences to the client.

You can backdate a client's eligibility if s/he chooses a deductible. You cannot backdate BC eligibility.

5.7.7.1 Changing a Choice

The choice between BC and a deductible is a monthly decision. Once you confirm a choice in CARES, the choice is locked in for that month and can only change for the recurring month.

5.7.7.2 Deductible Met

Once the deductible is met, a client cannot change the choice to BC for the duration of the deductible.

This page last updated in Release Number : 02-04
Release Date: 10/01/03
Effective Date: 10/01/03

5.7.8 PREMIUMS

As a condition of their BC eligibility, families who are eligible with total family income that exceeds 150% FPL (8.1.6) for their group size must pay a premium in order to receive BC. The premium is calculated based on the total family income and will be no more than 5% of that income amount.

Compare the total family income (5.7.6.2) to the table in 8.1.11 to determine the premium. Payment or non-payment of the premium does not affect the eligibility of any person in the household who qualifies under a different MA sub-program (Healthy Start, AFDC-Related MA, etc.). The premium is due in the benefit month, except for initial eligibility with a free month (5.7.8.1).

5.7.8.1 Initial Eligibility

The first month is free if no one in the FTG (5.7.5) was on MA or BC in the previous month, and the BC AG has not received a free month in the previous 12 months. Consider someone with an unmet deductible as not being on MA.

5.7.8.1.1 Processing Timeframe

In certain circumstances, a client may need to pay his/her premium for the first and/or second month following the free month before eligibility can begin depending on when his/her application is processed. The following indicates the eligibility and timeframe for premium payments:

1. Eligibility and Processing Occur in the Month of Application.

   When an application is processed in the same month it was received, and there is a free month, the premium for the second month must be paid in advance before BC eligibility can begin.

Example 1: Lisa and her family apply for MA and BC in January. They are determined eligible beginning January 1st. January is the free month. Lisa must pay the premium for her family for February before the family's BC eligibility can begin.

2. Eligibility Begins in the Month of Application – Processing Occurs in a Future Month.

   When an application is not processed within 30 days, and there is a free month, the family must pay both the second and third months' premium. CARES requires that the second and third months' premiums be paid before opening when eligibility is processed any time in the third month.

Example 2: Cheryl and her family apply for MA on March 25th. No one in her FTG was on MA in the previous month. Her worker extends the 30-day processing time period. Her family is approved for BC on May 2nd with eligibility beginning March 1st. March is Cheryl's free month. Cheryl must pay the premium amount for April and May before BC eligibility can begin.

3. Eligibility Begins in a Future Month – Processed in the Month of Application.

   When an application is processed within 30 days and eligibility does not begin until a future month, the free month is the first future month of eligibility. The client will receive a coupon for the premium amount. S/he must pay the second month's premium by the tenth of the benefit month to remain eligible for BC. The client is responsible for paying the premium as described in 5.7.8.2.

Example 3: Arnie and his family apply for BC on April 12th. He and his family are first eligible for BC beginning May 1st. May is the free month. A coupon for Arnie's June premium is mailed out May 20th. Arnie must pay his premium by June 10th.

5.7.8.1.2 Previous MA/BC Eligibility

If someone in the FTG was on MA the previous month or current month, s/he must pay the first month's premium. If the first month of BC eligibility is this month or a prior month, the premium must be paid in advance before eligibility can begin. If the first month of eligibility is a future month, no advance premium is due.

5.7.8.1.3 Initial Premium Payment

The Economic Support Agency (ESA) collects advance Payment payments and the worker records the payment in CARES. Payment must be either a check (personal, cashiers, travelers, etc.) or a money order. Do not accept cash. The check must be made out to BadgerCare'. Complete a BC premium coupon. Write in the client's Medicaid ID number on the BC premium coupon and on the check. Mail the client's initial BC premium payment (check or money order) and completed BC premium coupon directly to the BadgerCare lockbox at:

BadgerCare
c/o Wisconsin Department of Health and Family Services
Box 93187
Milwaukee, WI 53293-0187

Do not co-mingle the money with other county or tribal funds. Do not combine all premiums into a county/tribal agency check.

Each agency should have a supply of blank BC premium coupons, BadgerCare

Premium Employer Wage Withholding forms (HCF-13025), BadgerCare Premium Recipient/ Employer Electronic Funds Transfer forms (HCF-13026) and pre-addressed envelopes.

5.7.8.2 Premium Payment

Premiums can be paid by anyone. Ask the client to identify a payor when a premium is owed, and enter that information into CARES. Regardless of who pays the premium, the premium payor identified in CARES must be a household member, and is responsible for the payment of the premium. EDS uses that information when sending the first coupon. The premium month is the benefit month.

5.7.8.2.1 Reduced Premiums for Native Americans/Alaskan Natives

Some Native Americans or Alaskan Natives paying BC for Native Americans/ premiums may be eligible for a reduced premium amount. The premium amount is reduced by 35.7%, which is the amount designated for the children in the household. This amount does not change regardless of the number of children in the household eligible for BC. There is no premium obligation if the only BC eligible household members are Native American or Alaskan Native children.

EDS sends corrected coupons for future benefit months for Native Americans/ tribal members that have been identified as having a reduced premium amount. Tribal outreach workers will submit the necessary information to EDS to establish the client as eligible for a refund (5.7.8.2.4), which will establish the client at EDS as eligible for a reduced premium amount. Refer any clients that are potentially eligible for a reduced premium to their local tribal agency. Refer clients that have questions about the reduced premium coupons to the BadgerCare Unit at 1-888-907-4455.

A reduced premium amount will not be reflected in the CARES premium records. View adjusted premium amounts on the BD screen on MMIS.

5.7.8.2.2 Payment Method

When requested, EDS will provide clients with instructions for choosing the payment method they want. Clients can contact the BadgerCare Unit, 1-888-907-4455.

The payment methods are:

1. Direct payment by check or money order.
2. Electronic Funds Transfer (EFT).
3. Wage withholding from each paycheck received.
4. (Unlike Child Support, there is no statutory requirement that the employer participate in BC premium wage withholding. If the employer decides not to participate, the client will have to choose direct pay or EFT.)

Provide clients with the Wage Withholding (HCF-13025) and EFT (HCF-13026

) forms to allow the client to choose a payment method other than direct payment. Instruct the client to mail the completed forms to the address listed on the forms once s/he has chosen a payment method. Since it takes some time to set up EFT and wage withholding, the client pays directly until EDS informs them otherwise.

5.7.8.2.3 Advance Payments

Payments can be made in advance (further than the next month), but the payment cannot exceed the current certification period.

If paying in advance, the payments must be the full amount of subsequent month's premiums (no partial monthly payments). If the income amount changes, recalculate the premium. The client will be notified through CARES that his/her premium amount has changed. If the premium amount has decreased, EDS will refund any excess premium that was paid. If the premium amount has increased and the premium coupon has not been sent for that month, the client will receive a coupon with the new premium amount. If the premium coupons have already been sent, the client will need to pay the additional amount owed. The client will not receive a coupon for the difference that is owed.

5.7.8.2.4 Refunds

Contact the BadgerCare Unit to issue a refund if the premium was paid in advance if the premium is for one of the following:

1. A month that the AG was ineligible for BC.

2. A month that the AG's budgetable income drops to or below 150% of the FPL (8.1.6) and the income change was reported within ten days of the date the change occurred.

3. A month which requires a lower premium amount due to a change in circumstances which was in effect for the entire month so long as the change was reported within ten days of the date it occurred. The lower premium amount due is the first day of the month in which the change was reported. A refund for the difference will be issued.

Native American/Alaskan Native Premium Refunds

Native Americans or Alaskan Natives paying BC premiums can receive a refund of the portion of the BC premium that is designated for children in the household. The refund is 35.7% of the premium amount, regardless of the number of children in the household eligible for BC. If a premium has been paid for a case in which the only eligible household members are Native American or Alaskan Native children, a full refund of the premium amount will be made. EDS will send corrected coupons for future benefit months for those tribal members that have been identified as having a reduced premium amount.

Those who are eligible to receive a refund of part, or all, of their BC premium must meet all of the following criteria:

1. Have a child in the household who is:

    a. A Native American or Alaskan Native tribal member, **or**
    b. A natural or adoptive child of a Native American, **or**
    c. Alaskan Native tribal member, **or**
    d. Possesses a letter identifying the child as a descendant of a Native American or Alaskan Native tribal member, **or**
    e. A natural or adoptive child of a household member that possesses a letter identifying the child as a descendent of a Native American or Alaskan Native tribal member, **and**

2. Have a child in the household who is eligible for BC, **and**

3. Have paid a premium for BC sometime after July 1, 1999. Tribal outreach workers will submit the necessary information to EDS to establish the client as eligible for the refund. Refer any clients who are potentially eligible for this refund to their local tribal agency.

A reduced premium amount will not be reflected in the CARES premium records. View adjusted premium amounts on the BD screen on MMIS. Do not issue notices regarding the refunds or reduced premium amounts. Refer clients that have questions about the status of a refund and/or a reduced premium amount to the BadgerCare Unit at 1-888-907-4455.

5.7.8.3 On-going Payment

On-going premium payments are sent directly to the BadgerCare lockbox at:

BadgerCare
c/o Wisconsin Department of Health and Family Services
Box 93187
Milwaukee, WI 53293-0187

Checks are made out to 'BadgerCare'. BC premiums are due on the tenth of the benefit month, no matter which payment method is chosen. For families who have chosen 'direct pay' as their payment method, EDS sends out the BC premium coupons on the 20th of the month before the benefit month. EFT occurs on the third business day of the benefit month.

5.7.8.4 Late Payment

Cases are treated differently depending on when the late payment is received. The following explains the policy based on those time differences. Clients must pay the overdue payment(s) that closed the case, but do not have to pay the following month right away to open, unless the late pay is made after the benefit month.

Example 1: If the client owed a premium for September, and does not pay it until October, then s/he will need to pay both September and October. October eligibility will pend until the payment is received by the agency and recorded in CARES.

Between Due Date and Adverse Action of the Benefit Month

The case will stay open for the benefit month even if no payment is received by the due date. It will close at the end of the benefit month if no payment is received by adverse action in the benefit month.

Between Adverse Action of the Benefit Month and the Last Day of the Benefit Month

If the client pays between adverse action of the benefit month and the last day of the benefit month, s/he can reopen. Run SFED with dates and confirm.

Example 2: Adverse action is September 16th. Jim's September premium was due September 10th. Jim has not paid his September premium by September 16th. He pays on September 26th. The case closed effective September 30th. Run with dates to open for October. Then run without dates for November eligibility.

Anytime in Month After the Benefit Month

If the client pays any time in the month after the benefit month, s/he can reopen. S/he must pay the premium that closed the case. If s/he owes a premium for that following month, s/he must pay that premium before CARES will open BC. The client must pay you directly (not EDS). You can check with EDS to see if a premium has already been collected for that month.

When you get the payment(s), record the payment in CARES and run SFED for the benefit month and confirm. Then run SFED for the following month, and confirm.

Example 3: Adverse action is September 16th. Jim has not paid his September premium by September 16th. He finally pays on October 26th. His case closed for October. Jim must pay both the premiums for September and October since they were in arrears before he will open. To reopen the case, run SFED for October and confirm. Finally, run SFED for November and confirm. (The November premium is not due until November 10th and does not have to be paid in advance.)

Two Months After the Benefit Month

If the client pays in the second month after the benefit month, it's a non-payment (5.7.8.5).

5.7.8.5 Non-Payment

If the BC AG does not pay the monthly premium by adverse action in the benefit month, apply a restrictive re-enrollment period (RRP), unless there is good cause (5.7.9.2). The RRP begins with the first month of closure. If a late payment is received by the end of the month after the benefit month, lift the RRP.

5.7.8.5.1 Insufficient Funds

You will be notified with an 056 “Run SFED/SFEX” alert in CARES if a BC client pays the monthly premium through EFT or direct payment by check, and the payment is rejected for insufficient funds. Apply a restrictive re-enrollment period (RRP), unless there is good cause (anything beyond the client's control), and close the case. The RRP begins with the first month after closure. Determine if an overpayment exists, and process the overpayment (5.7.10.1).

5.7.8.6 Changes

Lower Premium - When a change is reported that results in a lower premium amount, confirm eligibility for the entire AG. EDS will refund any excess premium that was paid. The effective month of the lower premium is the month in which the change occurred or the month in which it was reported, whichever is later.

Higher Premium - When a change is reported that results in a premium for the first time or a higher premium, you must give notice to the client. CARES will not allow you to confirm if the notice requirement cannot be met. The increase is effective the following month if BC eligibility is confirmed before adverse action. If the change is confirmed after adverse action, the increase is not effective until the month after the following month.

Example: Jessica has BC with a premium for her and her family. She reports a change in income to her worker on April 23rd that results in a higher premium amount. Jessica's premium will not increase until June 1st. She will receive the coupon for the new premium amount at the end of May.

5.7.8.6.1 Person Adds

Lower Premium - When adding a person to the group results in a lower premium, add the person to the group on CARES and confirm eligibility for the whole AG. EDS will refund any excess premium that was paid.

Example 1 : A child with no income is added to the group. The group's income is now below 150% FPL (8.1.6) so it no longer owes a premium. EDS will refund the premium.

Higher Premium - You must give a notice to the client when adding a person to the group causes the group to pay a premium for the first time or to pay a higher premium. CARES will not allow you to confirm if the notice requirement cannot be met. Certify the new person by completing and returning the HCF 10110 (formerly DES 3070) for the period you cannot confirm eligibility in CARES.

- Mail:
  EDS
  P.O. Box 7636
  Madison, WI 53707
- E-mail: eds_3070@dhfs.state.wi.us
- Fax: (608) 221-8815

The increase is effective the following month if the person add was before adverse action.

Example 2: Mike was added to Rachel's case on June 6th (before adverse action). His income caused a premium increase. The increase is effective July 1st. Certify Mike's BC eligibility effective June 6th by sending in a HCF 10110 for the dates between June 6th and June 30th.

If the person add was after adverse action, the increase is not effective until the second month.

Example 3: Ann was added to the case on December 22nd (after adverse action). Her income caused a premium increase. The increase is not effective until February 1st. December and January premiums are correct. Certify Ann's BC eligibility effective December 22nd by sending in a HCF 10110 for the dates between December 22nd and January 31st.

5.7.9 RESTRICTIVE RE-ENROLLMENT PERIOD (RRP)

An AG who owes a premium for the current month who leaves BC by quitting or not paying a premium may be subject to a restrictive re-enrollment period. A restrictive re-enrollment period (RRP) means the BC AG cannot re-enroll in BC for six months from the termination date.

> **Example 1**: The client had an income increase which leads to a November premium. Previously she did not owe a premium. S/he tells the worker October 20th, (after Adverse Action), that s/he does not want BC for November. Since the client does not owe a premium in October, s/he does not receive an RRP, even though s/he will receive an additional month of BC in November. (It is too late to close BC for November.)
>
> **Note**: If she does not pay the November premium, she will have to pay it before she can be eligible for BC again (5.7.8.4).
>
> For this same case, the client does not tell the worker until November 2nd that they do not want BC for November. Since the client owes a premium in the current month of November, s/he does receive an RRP beginning in December.

5.7.9.1 Good Cause for Quitting BC

Do not apply the RRP when an AG who owes a premium for Quitting BC the current month voluntarily quits BC for these reasons:

1. No person is non-financially eligible for BC.
2. The AG moved out of Wisconsin.
3. Health insurance became available for the AG.
4. Entire AG is now MA eligible.
5. The AG has an increase in income that makes them BC ineligible.

5.7.9.2 Good Cause for Non-Payment

Good cause reasons for not paying the BC premium are:

1. Problems with the financial institution.
2. System problem.
3. Local agency problem.
4. Wage withholding problem.
5. Fair hearing decision.

The client must still pay the arrears before eligibility will begin again.

5.7.9.3 Household Changes

End the RRP when an adult member of the former BC AG leaves the home during the RRP for one full calendar month. Begin BC eligibility the first of the month after the month the adult left. The BC AG must pay any arrears before eligibility starts again. The AG does not have to make payments for months they were ineligible.

Example: Dad leaves the home on May 20th. On June 20th he has been out of the home a full calendar month. Mom and the kids may be BC eligible starting July 1st.

5.7.9 4 Reapplying

An AG who applies for BC before the end of the RRP is ineligible. The AG must serve the full six-month penalty period. Eligibility may begin again in month seven. Exceptions are found in 5.7.9.1, 5.7.9.2 and 5.7.9.3.

S/he must pay all arrears for months s/he was eligible. After the client has been off BC for 12 months, the arrears are forgiven.

This page last updated in Release Number: 03-02
Release Date: 01/01/03
Effective Date: 01/01/03

5.7.10 ADMINISTRATION

Clients have the right to a fair hearing, timely case decisions, and accurate notices of decision. See the IMM for specifics.

5.7.10.1 Notices

A client must receive a notice at least ten days prior to the negative action such as closing or an increase in premium. If the premium will increase and the notice requirement cannot be met, CARES will not allow you to confirm the increase.

This page last updated in Release Number: 03-02
Release Date: 01/01/03
Effective Date: 01/01/03

EBD RELATED MA

5.8 INSTITUTIONS

5.8.1 INSTITUTION

For MA purposes, "institution" means medical institution. A medical institution can be, but is not limited to, skilled nursing facilities (SNF), intermediate care facilities (ICF), institutions for mental disease (IMD), and hospitals.

Medical institution means a facility that:

1. Is organized to provide medical care, including nursing and convalescent care,

2. Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of patients on a continuing basis in accordance with accepted standards,

3. Is authorized under State law to provide medical care, and,

4. Is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

5.8.1.1 Institutions for Mental Disease

IMDs are medical institutions that care for persons with mental illness. See the list of IMDs (5.8.11).

5.8.1.1.1 Eligible Age

IMD residents under age 21 and over age 64 may be MA eligible. Persons aged 21 through 64 are not eligible unless they were IMD residents immediately prior to turning age 21. If they were, they are eligible until discharge or until turning age 22, whichever comes first.

5.8.1.1.2 Temporary Leave

A person aged 21 through 64 can go on conditional release from an IMD or convalescent leave and become eligible for MA while on leave.

1. Conditional release means a temporary release from an IMD for a trial period of residence in the community.

a. The trial period must last no less than four days. It must be no longer than 30 days.

b. The trial period begins after the initial three days of community residence following discharge.

c. A person under age 22 who leaves the IMD for a trial period remains eligible as an IMD resident until s/he is unconditionally released from the IMD.

For purposes of MA, conditional release is permitted only once every calendar year.

2. Convalescent leave means a period of time following inpatient admission of a resident of an IMD to a general hospital for the purpose of treatment for a physical medical condition of a severity which medically contraindicates treatment of the condition in the IMD.

5.8.1.2 Hospitals

Hospitals are medical institutions that:

1. Provide 24-hour continuous nursing care,
2. Provide dietary, diagnostic, and therapeutic services, and,
3. Have a professional staff composed only of physicians and surgeons, or of physicians, surgeons and doctors of dental surgery.

A person residing in a hospital is an institutionalized person (5.8.4.1) if s/he:

1. Has resided in a medical institution for 30 or more consecutive days, or

2. Is likely to reside in a medical institution for 30 or more consecutive days.

The 30-day period includes situations in which the person resides in more than one medical institution during 30 or more consecutive days.

5.8.1.3 Minors in IMD

When a minor applies for MA after being discharged from the IMD, certify the individual as a recipient, if eligible, for the inpatient IMD days only. Certify for the remainder of the month if s/he would be eligible after being tested for Family MA with his/her parents and siblings.

This page last updated in Release Number : 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

5.8.2 LICENSING & CERTIFICATION

Medical institutions (SNFs, ICFs, IMDs, hospitals) are licensed under Chapter 50, Wis. Stats. The Division of Public Health, Bureau of Quality Assurance, is the licensing agency.

In order to receive MA payment for the care and services they provide, medical institutions must comply with federal MA requirements. The agency which certifies their compliance is the Division of Health Care Financing.

This page last updated in Release Number : 03-01
Release Date: 01/01/03
Effective Date: 01/01/03

5.8.3 FACILITIES NOT MA CERTIFIED

Determine the eligibility of persons in non-certified facilities in the same way as for those in certified facilities. MA will not pay cost of care for these persons, but they may still be eligible for MA card services (4.7.15).

This page last updated in Release Number : 03-01
Release Date: 01/01/03
Effective Date: 01/01/03

5.8.4 DEFINITIONS

5.8.4.1 Institutionalized Person

“Institutionalized person” means someone who:

1. Has resided in a medical institution for 30 or more consecutive days, or
2. Is likely to reside in a medical institution for 30 or more consecutive days, as attested to by the medical institution.

For purposes of divestment and spousal impoverishment, consider community waivers participants to be institutionalized.

An exception to the 30-day period is that a resident of an IMD is considered an institutionalized person until s/he is discharged.

The 30-day period includes situations in which the person resides in more than one medical institution during 30 or more consecutive days.

5.8.4.2 Community Spouse

A “community spouse” is:

1. Married to an institutionalized person, and
2. Not living in a nursing home or other medical institution for 30 or more consecutive days.

5.8.4.3 SSI Recipient and Institutional MA application

An SSI recipient who has resided or is likely to reside in a medical institution for 30 days or more may apply and be non-financially eligible for institutional Medicaid if the SSA will discontinue the person's SSI because of the financial effect of his/her residence in the medical institution.

An SSI recipient who has not resided or is not likely to reside in a medical institution for 30 days or more is non-financially ineligible for institutional Medicaid. The person remains Medicaid eligible through SSI.

This page last updated in Release Number : 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

5.8.5 FINANCIAL

(1) Assets

Refer to (4.5.1) to determine when an asset is countable. If countable assets exceed the appropriate limit, the Medicaid applicant/recipient is ineligible.

NOTE: Prepayment to a nursing home for the extra cost of a private room is an available asset. The applicant has the legal ability to make the prepayment available for his/her support and maintenance (4.5.2).

a. Unmarried client.
   See 8.1.5 for the EBD asset limits for an unmarried client.

b. Married client (Spousal Impoverishment) The assets of both the institutionalized person and his/her community spouse are counted in the initial asset test. For information about how to determine a married client's asset limit and the community spouse asset share refer to (5.10.4).

(2) Income

Follow the policies listed in 4.1 to determine an applicant's income. The income limit is the same for non-spousal impoverishment institutionalized persons as for spousal impoverishment cases. But, for spousal impoverishment cases, after the institutionalized person becomes eligible, s/he is allowed to allocate some of his/her income back to his/her community spouse. (5.10.6)

If income is greater than Institutions Categorically Needy Income Limit (8.1.5) the person is ineligible for categorically needy MA.

If the income is greater than need (5.8.6) the person is ineligible for medical needy MA.

Sometimes, when both spouses are institutionalized, the income of one is greater than his/her monthly need and the income of the other is less than his/her monthly need. When this occurs, calculate the couple's combined monthly need and compare it with their combined income. If the total need is greater than the total income, and if the spouse with greater income is willing to combine it with his/her spouse's lesser income, both spouses could be eligible.

5.8.5.1 Divestment

See 4.7 for Divestment policies.

5.8.5.2 Instructions for Manual Eligibility Determinations

Use the following to determine which financial worksheet to use:

1. Medical institution (5.8.1) residents with no community spouse (5.10.2.1).

   Use the MA Institution Worksheet (Worksheet #4).

2. Medical institution residents who have a community spouse and who became institutionalized before 9-30-89:

Use the HCF 10095 Medicaid Asset Assessment Medical Institution/Community Waiver Resident and Community Spouse Form and the MA Institution Worksheet (Worksheet #4).

3. Medical institution residents who have a community spouse and who became institutionalized on or after 9- 30-89:

   Use the HCF 10095 Medicaid Asset Assessment Medical Institution/Community Waiver Resident and Community Spouse Form and the Spousal Impoverishment Income Allocation Worksheet (Worksheet #7).

4. Community waiver applicants with no community spouse:

   Use the HCF 10095 Medicaid Asset Assessment Medical Institution/Community Waiver Resident and Community Spouse Form.

5. Community waiver applicants with a community spouse:

   Use the HCF 10095 Medicaid Asset Assessment Medical Institution/Community Waiver Resident and Community Spouse Form.

This page last updated in Release Number : 05-01
Release Date: 01/11/05
Effective Date: 01/11/05

5.8.6 MONTHLY NEED

Monthly need is the amount by which the institutionalized person's expenses exceed his/her income. It is computed by adding together the following monthly costs:

1. Personal needs allowance (8.1.5.1).
2. Cost of institutional care (use private care rate).
3. Cost of health insurance (5.8.6.3).
4. Support payments (4.1.3.2.1).
5. Out-of-pocket medical costs.
6. Work related expenses (4.1.3.4).
7. Self-support plan (4.1.3.2.2).
8. Expenses for establishing and maintaining a court- ordered guardianship or protective placement, including court ordered attorney or guardian fees.
9. Other Medical Expenses.
10. Other deductible expenses.

5.8.6.1 Hospitalized Persons

When you determine a hospitalized person's monthly need use the average daily charge for the hospital the person is in. See 8.1.9. If his/her hospital is not on the list, enter $2,318.08 on ANII.

5.8.6.2 Both Spouses Institutionalized

If both spouses are institutionalized and one has income greater than his/her monthly need, calculate the couple's combined monthly need and compare it to their monthly income. If their combined monthly need exceeds their combined monthly income, both spouses may become eligible.

5.8.6.3 Health Insurance

Allow health insurance costs only if the primary person is the owner of the policy and is billed for the premium.

Do not deduct health insurance premiums for health insurance that pays for more than the cost of medical care. An insurance policy which pays for accidental injuries, does not qualify as a health insurance premium and cannot be deducted.

When a person pays premiums less often than once a month, prorate the premium to find the monthly amount. Deduct the monthly amount from the monthly income.

The accumulation of these premium amounts is an exempt asset. Exempt them for a period over which they have been prorated.

Example: Mr. W. pays a health insurance premium of $600 every quarter. The monthly amount, prorated over three months, is $200. Deduct $200 from Mr. W's monthly income. Each quarter, exempt $600 of Mr. W's assets until that quarter's premium due date.

5.8.6.3.1 Nursing Home and Hospital Insurance

Nursing home and hospital insurance polices are indemnification policies. Indemnification policies provide benefits in a fixed amount for a confinement, such as a hospitalization, regardless of the expenses actually incurred by the insured.

Nursing home and hospital insurance policies pay a flat rate to the policy holder for each day that s/he resides in the nursing home or hospital, respectively.

Consider nursing home and hospital insurance as a type of medical insurance. Allow the premiums as a deduction in the eligibility test and post-eligibility calculation.

5.8.6.3.2 Assignment of Nursing Home and Hospital Insurance Payments

All clients must cooperate in providing Third Party Liability (TPL) coverage and access information (6.3.3.5). All clients must sign over to the State of Wisconsin all their rights to payments from hospital or nursing home insurance (6.3.3.5.1). Terminate eligibility for any individual that will not cooperate in:

1. Providing TPL coverage and access information.

2. Turning over payments from indemnity insurance policies.

5.8.6.4 Support Payments

Support payments are payments which an institutionalized MA client makes to another person for the purpose of supporting and maintaining that person. See 4.1.3.2.1.

5.8.6.5 Fees to Guardians or Attorneys

See 4.1.3.2.3.

This page last updated in Release Number : 02-03
Release Date : 07-01-02
Effective Date :07-01-02

5.8.7 COST OF CARE CALCULATION

After you have determined that an institutionalized person is eligible for MA, you must calculate his/her cost of care. Cost of care is the amount s/he will pay each month to partially offset the cost of his/her MA services. It is called the patient liability amount when applied to a nursing home resident, and cost share when applied to a community waivers client, Pace/ Partnership, or Family Care client.

Calculate the cost of care in the following way:

1. For a MA client in a nursing home who does not have a community spouse, subtract the following from the person’s monthly income:

    a. $65 and ½ earned income disregard (4.1.3.6).
    b. Monthly cost for health insurance (5.8.6.3).
    c. Support payments (4.1.3.2.1).
    d. Personal needs allowance (8.1.5.1).
    e. Home maintenance costs, if applicable (4.1.3.1).
    f. Expenses for establishing and maintaining a court-ordered guardianship or protective placement, including court-ordered attorney

and/or guardian fees (4.1.3.2.3).

2. For a MA client in a nursing home who has a community spouse, follow the directions in 5.10.

3. For a community waivers client with or without a community spouse, follow the directions in 5.9.

4. For a hospitalized person, there is no cost of care. There is no system available yet to collect a hospitalized person's cost of care.

5. There is no cost of care for SSI recipients.

6. For a MA client who was or could have been certified through a deductible before entering the institution, there is no cost of care until the deductible period ends.

If the cost of care amount is equal to or more than the nursing home's Medicaid rate, the individual is responsible for the entire cost of his/her institutional care. S/he would be entitled to keep any overage without restriction. S/he would remain eligible for the Medicaid program and have no further financial obligation to the Medicaid program for that month.

5.8.7.1 Hospitalized Persons

Do not calculate or report a patient liability for a hospitalized person. See 5.8.7.4.2 and 5.8.7.4.3 for information about patient liability calculations when a person transfers between a hospital and nursing home(s).

5.8.7.2 Managed Care Programs

Payment procedures are different for institutionalized Family Care or Pace/Partnership clients. These clients pay their cost share to the Managed Care Program instead of to the nursing home. The program then pays the nursing home.

5.8.7.3 Partial Months

If a client is not MA eligible and residing in an institution (5.8.1) as of the first of the month, there is no patient liability for that month.

Exception: There is a patient liability if the reason why the person didn't reside in the institution for the entire month was due to death or being on Theraputic leave.

5.8.7.3.1 Death

If the patient liability amount in the month of death is greater than the nursing home's cost of care for that month send a completed HCF 10110 (formerly DES 3070) form to:

Mail: EDS
P.O. Box 7636
Madison, WI 53707

E-mail: eds_3070@dhfs.state.wi.us

Fax: (608) 221-8815

Indicate the patient liability amount as equal to the nursing home charges for the month. This is done for potential retroactive nursing home rate adjustments. The nursing home will notify the Estate Recovery Program (ERP) of who received the excess income. ERP will attempt recovery even if the money goes to the heir directly. ERP uses the same process to recover this excess income as it does for recovering patient fund accounts (6.1.5.7).

5.8.7.3.2 Community and Nursing Home

There is no patient liability in a month a client moves from:

1. The community into a nursing home after the first of the month, or

2. From a nursing home to the community before the end of the month.

5.8.7.4 Transfers Between Institutions

When an institutionalized person transfers between institutions, calculate the patient liability due each institution. Send a completed Notice to Institutions, Nursing Home, Client form (HCF 10108) to notify the client and institution. Return a completed Medicaid/BadgerCare Certification form (HCF 10110, formerly DES 3070) to EDS.

5.8.7.4.1 Transfer between Nursing Homes

If a client transfers between nursing homes, follow this procedure to divide the patient liability amount between them:

1. Divide the monthly patient liability amount by the number of days in the month of change. This results in the daily prorated amount.

2. Multiply the daily prorated amount by the number of days in the month of change that s/he resided in the first nursing home. Allocate the resulting

amount to the first nursing home.

3. Multiply the daily prorated amount by the number of days in the month of change that s/he resided in the second nursing home. Allocate the resulting amount to the second nursing home.

Note: Do not count the day of the move twice. Count it for the nursing home to which s/he moved.

5.8.7.4.2 Nursing Home and Hospital

The entire patient liability amount is paid to the nursing home if a client moves from:

1. A nursing home to a hospital, or
2. A hospital to a nursing home, and
3. S/he has been continuously institutionalized for 30 days or more.

5.8.7.4.3 Multiple Nursing Homes and a Hospital

If a client moves from a nursing home to a hospital to a second nursing home, do not apply the income to the patient liability while in the hospital. The income is divided differently according to the timing of the moves.

If the client resides in two different nursing homes and a hospital all in the same month, divide the hospital days evenly and allocate those days to each nursing home. Then do the prorated calculation described in 5.8.7.4.1.

Send a Notice to Institutions, a Nursing Home, Client form (HCF 10108) to the client and the nursing homes. If the move to the hospital is mid-month and then to the second nursing home is in another month, the first nursing home gets the entire liability amount for month one and the second nursing home gets the entire liability amount for month two.

5.8.7.5 Retroactive Cost of Care

Occasionally a nursing home or community waivers applicant becomes retroactively eligible. This might happen, for example, when a person, having been denied eligibility, goes to a fair hearing. If the fair hearing determines the person was eligible at the time of application, the agency must retroactively certify him/her and compute retroactive cost of care. The directions are the same as for current cost of care (5.8.7).

5.8.7.6 Personal Needs Allowance

Deduct the personal needs allowance (8.1.5.1) for all institutionalized clients in both the eligibility test and the patient liability calculation.

5.8.7.7 Payment for Non-Covered Services

MA clients in nursing homes are allowed to pay for some medically necessary non-covered services out of their patient liability. They are not required to use their personal needs allowance for these services. Refer clients to their provider to make this adjustment.

This page last updated in Release Number : 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

5.8.8 NURSING HOME CONTRACTS

Certain nursing home contract provisions require prospective residents to be on private pay status for a period of time, usually 12 to 18 months, before applying for Medicaid (MA).

In essence, this requires the prospective resident waive the right to apply for MA for a period of time as a precondition to admittance. The prospective residents, who are typically on a higher private pay status at the time, would generally qualify for MA before the contract provision expires.

Nursing homes must honor residents' rights guaranteed by HSS 132.31, Wis. Admin. Code, in order to participate in the MA program. The standards must be enforced as a condition of federal funding. They apply to all residents in an MA certified nursing home, both MA and private pay, as a condition of participation in the MA program.

A resident can be involuntarily discharged or transferred essentially only for: (1) medical reasons, (2) his/her welfare or that of other patients, or (3) nonpayment. Changing status from private pay to MA and any corresponding loss of revenue to the nursing home are not to be considered nonpayment.

Thus, contract provisions prohibiting a person from applying for MA by requiring a certain length of stay as a private pay resident can't be enforced by threats of discharge.

DHFS has notified all Wisconsin nursing home providers that: (1) violations of private pay duration of stay contract provisions aren't grounds for discharge, and (2) they must notify all present and prospective residents of this.

This page last updated in Release Number : 03-03
Release Date: 09/22/03
Effective Date: 09/22/03

5.8.9 NURSING HOME REFUNDS

When an institutionalized person becomes eligible for MA, s/he is certified with a begin date of the first of the month in which s/he became eligible. If s/he prepaid his/her patient liability for that month, s/he is entitled to a refund. The nursing home must refund the amount s/he prepaid in the month in which s/he became eligible.

Treat the refund as a reimbursement in the month it is received. (4.1.2.8) Do not count it as income in the month it is received. Beginning with the month following the month of receipt, count any amount s/he keeps as an available asset. S/he can avoid having the reimbursement counted as an available asset by doing any of the following:

1. Transfer it for fair market value for an exempt asset.
2. Transfer it to his/her spouse.
3. Refund it to the MA program in an amount equal to what MA has already paid for his/her care up to the date of the reimbursement.

This page last updated in Release Number : 03-03
Release Date: 09/22/03
Effective Date: 09/22/03

5.8.10 LIABILITY EFFECTIVE DATES

Nursing homes, State centers, and State mental hospitals receive a CARES weekly paper report, #CCN150RA, that lists the patient liability amounts for their MA residents. The report includes case number, primary person name, patient liability status (approval, closure, increase, decrease, unchanged), the date the action was confirmed on AGEC, prior patient liability amount, current patient liability amount, effective begin date, and effective end date.

Income changes which are reported timely and result in an increased patient liability have the following effective dates:

1. Before cutoff, effective the first of the following month.
2. After cutoff, effective the first of the month after the following month.

Do not complete HCF 10110's (formerly DES 3070) for retroactive patient liability increases since the client must receive timely notice.

Decreases in patient liability are always effective the first of the month in which the decrease in income occurs or the decrease is reported, whichever is later. If the date of change that you enter into CARES will cause an incorrect effective date on the EDS file, run with dates in CARES. Do not complete a HCF 10110 (formerly DES 3070) unless you are unable to confirm the decrease after running with dates in CARES.

This page last updated in Release Number : 03-03
Release Date: 09/22/03
Effective Date: 09/22/03

5.8.11 INSTITUTIONS FOR MENTAL DISEASE (IMDs)

Brown
Bellin Psychiatric Center
Brown County Hospital
Libertas

Dane
Mendota Mental Health Institute

Fond du Lac
Fond du Lac County Health Care Center

Marathon
North Central Health Care Center
Norwood Health Center

Milwaukee
Milwaukee County Mental Health Complex
Milwaukee Psychiatric Hospital
Rogers Memorial Hospital

Waukesha
Rogers Memorial Hospital
Waukesha County Mental Health Center

Winnebago
Winnebago Mental Health Institute

If you have a question about an institution on this list, contact:

Division of Health Care Financing
Harvey Aures, Telephone: (608) 267-9698
Dave Bodoh, Telephone: (608) 267-9589

This page last updated in Release Number : 03-03
Release Date: 09/22/03
Effective Date: 09/22/03

5.9 COMMUNITY WAIVERS

5.9.1 introduction

Community waivers enable elderly, blind, and disabled (EBD) persons to live in community settings rather than in state institutions or nursing homes. They allow MA to pay for community services, which normally are not covered by MA.

Community waivers include the following programs:

1. Community Integration Program I (CIP 1A and CIP 1B).
2. Community Integration Program II (CIP II).
3. Community Options Program Waiver (COP-W) .
4. Brain Injury Waiver.
5. Community Supported Living Arrangements (CSLA).
6. Program of All-Inclusive Care for the Elderly (PACE).
7. Wisconsin Partnership Program (WPP).

To be eligible for these waivers, a person must:

1. Meet MA level of care requirements for admission to nursing homes, and
2. Meet non-financial requirements for MA, **and**
3. Meet financial requirements for MA, **and**
4. Reside in a setting allowed by community waivers policies, **and**
5. Have a need for long term care services.
6. Have a disability determination if they are under age 65. (Disability is a non-financial eligibility requirement for Community Waiver programs for anyone under age 65.)

This page last updated in Release Number: 04-01
Release Date: 02/01/04
Effective Date: 02/27/04

5.9.2 application

All waiver clients being discharged from a nursing home, and persons in non-institutional living arrangements must complete an application form unless they are already receiving full-benefit MA (7.1.2).

5.9.2.1 Case Manager

All waiver clients receive assessment and case planning services from a case manager. The case manager is responsible for determining a level of care and completing a service plan for each client. In some counties this function is performed at the Resource Center.

The service plan packet contains documentation verifying the person's eligibility for waivers. For Group A clients, case managers submit CARES eligibility and budget screens. (ECSC and ECED), or the MA Waiver Eligibility and Cost Sharing Worksheet (DDE-919). For Group B and C clients, the CARES eligibility and budget screens (ECSC and ECED) are submitted. DDE-919 serves as a backup to CARES.

5.9.2.2 Spousal Impoverishment

Spousal impoverishment policy applies to waiver participants with a community spouse, with the exception of Medicaid Purchase Plan (MAPP) waiver participants (5.10.2.3 and 5.12.3.6).

5.9.2.3 Minors

Minors (3.5.1.4) are not eligible for waiver services unless they have been determined disabled (3.6.1). Consider only the disabled child's assets and income unless the parents make an actual cash contribution to the child. If they do, include that amount as part of the child's unearned income (5.9.7).

5.9.2.4 Tentative Approval

Persons who apply for waivers other than PACE and WPP may receive tentative waiver approval from the Division of Disability and Elder Services (DDES) while their MA eligibility is being determined.

The tentative approval process begins when the case manager refers the waiver applicant to the ESA with accompanying information about the type of waiver, waiver begin date, medical/remedial expenses, and MA card coverable expenses. Enter the case into CARES and send the case manager the CARES screen prints showing the eligibility determination, cost share amount, family member allowance, and spenddown amount.

If it is a spousal impoverishment case, also send along the CARES screen prints or manual worksheets which show the spousal and family member income allocations. Complete a manual Spousal Impoverishment Income Allocation Worksheet (WKST 07 8.2.1) for any spousal impoverishment case that is Group C eligible. Send a copy of this worksheet or a modified copy of ECSC to the case manager. Send a manual notice to the client with the corrected cost share amount, if the cost share calculated on WKST 07 differs from the amount calculated in CARES.

The case manager then submits the screen prints and the service plan packet to DDES for tentative approval. Until the case manager informs you the case has been tentatively approved, keep it in pending status in CARES. After tentative approval is received, confirm the case on CARES. This will certify the person for MA.

5.9.3 fiscal test group

Form the fiscal test group as follows:

1. Single person = a fiscal test group of one.

2. Married couple, when one spouse is applying for community waivers, and the other is a community spouse (5.10.2.1). This is a spousal impoverishment situation. Combine the assets (5.10.4.2) and apply the spousal impoverishment asset test (5.10.4.3). The income limit is the same as for institutionalized persons who do not have a community spouse.

3. Married couple, both applying, are in two separate fiscal test groups. Spousal impoverishment policies may apply.

Example: Cathy and Bob, a married couple, are both applying for community waivers. Both are each other's community spouse. Combine the assets and apply the spousal impoverishment asset test. Calculate asset shares and asset limits for each. Cathy and Bob each have one year to spend assets down to $2,000, based on their individual application dates.

This page last updated in Release Number: 02-03
Release Date: 07/01/02
Effective Date: 07/01/02

5.9.4 divestment

When requested, assist the case manager in assessing divestment. See 4.7.1.

This page last updated in Release Number: 02-03
Release Date: 07/01/02
Effective Date: 07/01/02

5.9.5 cost sharing

Cost sharing is the monthly amount a waivers participant may have to contribute toward the cost of his/her waiver services. Count only the income of the client when you calculate the cost share.

Payment of the cost share is a condition of eligibility. See 5.9.9.2.1 for instructions about how to calculate a cost share.

5.9.5.1 Spenddown

The spenddown obligation is the amount a Group C waivers participant must incur monthly in medical/remedial expenses and/or MA card services to lower countable income to the Medically Needy Income limit (8.1.5). The care manager monitors and documents that this occurs monthly.

A single Group C waivers participant must:

1. Incur, **and**
2. Be held financially responsible for the spenddown amount on a monthly basis.

A married Group C waivers participant must:

1. Incur the spenddown amount, **and**
2. Pay the cost share monthly, if applicable.

This page last updated in Release Number: 03-03
Release Date: 09/01/02
Effective Date: 09/20/02

5.9.6 reserved

5.9.7 uniform fee system

Following the procedures of the Uniform Fee System (Chap. HSS 1, Wisconsin Administrative Code), the case manager determines if the parent(s) must contribute toward the care of a child who is in CIP IA, IB, II, or COP-W. When the parents are already contributing according to the Uniform Fee System, no additional contribution is required.

This page last updated in Release Number: 03-03
Release Date: 09/01/02
Effective Date: 03/20/03

5.9.8 effective date

The begin date of waiver eligibility is the date given in the approval letter sent by the DSL waiver staff to the county case manager/social worker.

Persons in Groups B and C will receive tentative approval of eligibility for waiver services when the case manager submits a waiver service plan packet to DSL and receives a tentative approval in return.

The start date stated in this tentative approval becomes the date of waiver eligibility if the person is determined eligible for MA as of that date.

This page last updated in Release Number: 03-03
Release Date: 09/01/02
Effective Date: 03/20/02

5.9.9 instructions

Eligibility for Group A, B, and C Community Waivers cases are determined in CARES. Group A Katie Beckett cases are processed manually outside of CARES.

Care managers will determine and certify community waiver eligibility for children already eligible for Medicaid through the Katie Beckett program. In addition, care managers will determine if divestment of the child's assets has taken place.

If so, a referral will be made to ES workers to determine manually if a penalty period exists. If a penalty period exists, the ES worker will notify the care manager, and the care manager will notify the applicant.

Katie Beckett waiver cases will now be considered "Group A". The Katie Beckett medical status code will be retained. Because of the small number of these cases, the certification process will not be automated in CARES. Certification will be processed manually by care managers and Katie Beckett staff.

Complete the Waiver Eligibility and Cost Sharing Worksheet (DDE-919) when an institutionalized client is going to be discharged, and enter the Community Waivers program.

When CARES screens are unavailable, use simulation or complete the DDE-919 as follows:

1. Fill out the identifying information at the top. The MA eligibility date is the date of most recent MA eligibility.

2. Fill out the financial information in Section I, Lines 1-4. When you have determined that the person is financially eligible, set the effective begin date of eligibility (5.9.8).

Read the descriptions of Groups A, B, and C below. After deciding which group the person is in, check the appropriate box in Section I. A person cannot be in more than one group at the same time.

5.9.9.1 Group A

Group A clients are defined as those waiver functionally eligible and MA eligible via SSI (including SSI-E and 1619A and B) or a full-benefit MA subprogram (7.1.2). This does not include someone solely eligible for any of the limited benefit MA subprograms (7.1.3).

Clients who have met a deductible are eligible for Community Waivers as a Group A. The client remains eligible as a Group A until the end of the deductible period. At the next review the client will be able to make a choice between meeting the deductible to receive MA (remaining a Group A) or becoming eligible for Community Waivers as a Group B with a potential cost share, or Group C with a potential spenddown/cost share.

Group A clients are financially eligible with no cost share. Put a check before Group A in Section I. Then complete Sections II and V on the worksheet.

5.9.9.2 Group B

Group B clients are defined as those not in Group A, but who have income at or below the nursing home institutions categorically needy income limit. (8.1.5) Calculate a cost share based on the client's income and allowable deductions.

Put a check before Group B in Section I. Then complete Sections III and V on the worksheet. Count only the income of each individual when you calculate that individual's cost share.

5.9.9.2.1 Personal Maintenance Allowance

The personal maintenance allowance (Line 6 and Page 2 of the worksheet) is for room, board, and personal expenses. It is the total of:

1. Community Waivers Basic Needs Allowance (8.1.5.1).

2. $65 and ½ earned income deduction (4.1.3.6).

3. Special housing amount. This is an amount of the person's income set aside to help pay housing costs. If the waiver applicant's housing costs are over $350, add together the following costs:

    a. Rent.

    b. Home or renters insurance.

    c. Mortgage.

    d. Property tax (including special assessments).

    e. Utilities (heat, water, sewer, electricity).

    f. "Room" amount for clients in a Community Based Residential Facility (CBRF), Residential Care Apartment Complex (RCAC) or an Adult Family/Foster Allowance.) Home (AFH). The case manager determines and provides this amount.

The total, minus $350, equals the special housing amount. The person can set this amount aside from his/her income.

If both spouses are applying and both have income, divide the special housing amount equally between them.

Example: Two spouses applying with income: $600 rent <u>- 350</u> = 250/2 spouses = $125 that each can set aside

If only one spouse has income and both spouses are applying, allocate the full special housing amount to the spouse with income.

Do not give the special housing amount to waiver participants under age 18.

The total of 1, 2, and 3 must not be greater than the EBD Maximum Personal Maintenance Allowance (8.1.5.1).

5.9.9.2.2 Family Maintenance Allowance

The family maintenance allowance is for the support of family members when spousal impoverishment policies do not apply. If the client is a disabled child, omit the family maintenance allowance.

Family Related - When the waiver participant is the custodial parent of a minor child living in the home, and there's no spouse in the home, do the following:

1. Minor children's gross earned income.
2. -$65 and ½ of gross earned income (4.1.3.6).
3. =______________.
4. + Minor Children's total unearned income.
5. = __________Add (3) and (4).
6. AFDC Related med needy income limit _______ (8.1.4). (Do not include the waiver applicant in the group size.)

If (5) is greater than (6), there's no family maintenance allowance. If (5) is less than (6), the family maintenance allowance is the difference between (5) and (6).

EBD Related - If there are no minor children in the home, and spousal impoverishment policies do not apply, do the following:

1. Spouse's gross earned income.

2. -$65 and ½ of total gross earned income (4.1.3.6).

3. =___________.

4. +Spouse's total unearned income.

5. =_________________ (3)+(4).

6. -$20 disregard.

7. =__________________(6)-(5).

8. _____________Enter the SSI Payment Level Plus the E Supplement for one person (8.1.5)

If (7) is greater than (8) there is no family maintenance allowance. If (7) is less than (8) the family maintenance allowance is the difference between (7) and (8).

5.9.9.2.3 Special Exempt Income

Deduct special exempt income (4.1.3.2).

5.9.9.2.4 Health Insurance

Include all health and dental insurance premiums covering the waiver person and for which s/he is responsible and pays. See 6.3.4 for a list of insurance types for which premium deductions are not allowed.

If the waiver participant is part of a covered group, but not responsible for the premium, find his/her proportionate share by dividing the premium by the number of people covered. If both members of a couple apply, but only one pays the premium, divide the premium equally. Prorate premiums over the months payment covers.

Example: Sally pays a $600 premium quarterly for her Medicare supplement policy. $600 divided by three equals $200. Enter $200 as her monthly health insurance premium payment on AFMC.

5.9.9.2.5 Medical/Remedial Expenses

Obtain the dollar amount for medical and remedial expenses (Line 10) from the case manager. See 4.1.3.3 for definitions.

5.9.9.2.6 Cost Share Amount

The waiver cost share amount (Line 12) is the monthly amount s/he must pay toward the cost of his/her waiver services.

Institutionalized Pace/Partnership or Family Care enrollees pay their cost share to the Managed Care Program instead of the institution.

5.9.9.3 Group C

Persons in Group C meet the medically needy income test for waiver clients.

Put a check before Group C in Section I. Complete Sections IV and V.

Most Group C members have a monthly spenddown. They must meet the spenddown each month to remain eligible. The case manager monitors the monthly spenddown.

This page last updated in Release Number: 02-04
Release Date: 10/01/02
Effective Date: 10/01/02

5.9.10 medical codes

See the CARES Guide, Chapter IV, Part D, 7.0.0, for Community Waiver medical status codes. These are not the same codes as nursing home medical status codes. A medically needy MA client could be eligible as a categorically needy waiver client (Group B), thus requiring a change in the medical status code from medically needy to categorically needy.

This page last updated in Release Number: 02-04
Release Date: 10/01/02
Effective Date: 10/01/02

5.9.11 review

Review financial eligibility annually. The case manager reviews level of care eligibility annually. Do not discontinue eligibility if the case manager has not yet made the level of care review.

The case manager informs the ESA if the person is no longer level of care eligible. Notify the case manager if the person is no longer MA eligible.

This page last updated in Release Number: 02-04
Release Date: 10/01/02
Effective Date: 10/01/02

5.9.12 community spouse's ma application

When a community waivers person and his/her community MA Application spouse are both applying for MA, they are one case, but separate AGs. Enter them in CARES on the same application. Only one of the spouse's signature is needed on the application.

Both spouses are in the non-waiver spouse's fiscal test group (FTG). Since the waiver spouse is in the FTG, disregard any income that may have been allocated by the waiver spouse to the community spouse.

The waivers spouse is a FTG of one. CARES creates the separate FTG's and AG's.

This page last updated in Release Number: 04-01
Release Date: 02/01/04
Effective Date: 02/01/04

5.9.13 notices

CARES generates a Notice of Decision each time the ES confirms a case.

This page last updated in Release Number: 04-01
Release Date: 02/01/04
Effective Date: 02/01/04

5.9.14 transfers

When a Community Waivers case transfers to a new county or tribe, and there is no slot available in the new agency, do the following:

Transfer the case to the new county through CARES. The transfer-in county takes care of the MA certification. The transfer-out county keeps the client in the waiver slot until a slot becomes available in the new county.

This page last updated in Release Number: 04-01
Release Date: 02/01/04
Effective Date: 02/01/04

5.10 SPOUSAL IMPOVERISHMENT

5.10.1 DESCRIPTION

Spousal impoverishment is an MA policy that allows persons to retain assets and income that are above the regular MA financial limits. Spousal impoverishment policy applies to institutionalized persons (5.10.2.3) and their community spouse (5.10.2.1).

The policy's purpose is to prevent impoverishment of the community spouse. Before enactment of the Medicare Catastrophic Coverage Act of 1988, the community spouse was legally obliged to provide financial support to the institutionalized person. After enactment, s/he is allowed to have substantial assets and income without liability for the institutionalized spouse and without affecting the MA eligibility of the institutionalized spouse.

This page last updated in Release Number : 01-02
Release Date: 04/01/00
Effective Date: 04/01/00

5.10.2 useful terms

5.10.2.1 Community Spouse

A "community spouse" is:

1. Married to an institutionalized person and

2. Not living in a nursing home or other medical institution for 30 or more consecutive days.

As long as the community spouse is not an institutionalized person, his/her living arrangement can have no effect on his/her asset share (5.10.2.2) or income allocation (5.10.6).

Example: Joe is an institutionalized person living in a nursing home. His wife, Carla, is in prison. Carla is entitled to the community spouse asset share and to any allowable income which Joe chooses to allocate to her.

5.10.2.2 Community Spouse

The community spouse asset share (CSAS) is the amount of countable assets above $2,000 that the community spouse, the institutionalized person, or both, can possess at the time the institutionalized person **applies for MA**. Once the institutionalized spouse is determined eligible, the assets of the community spouse are unavailable

5.10.2.3 Institutionalized

"Institutionalized person" means someone who:

1. Participates in Community Waivers, or

2. Has resided in a medical institution for 30 or more consecutive days, or

3. Is likely to reside in a medical institution for 30 or more consecutive days, as attested to by the medical institution.

An exception to the 30 day period is that a resident of an IMD (5.8.1.1) is considered an institutionalized person until s/he is discharged. The 30 day period includes situations in which the person resides in more than 1 medical institution during 30 or more consecutive days.

If a person relocates from one institutional living arrangement to another, consider him/her to be in a continuous period of institutionalization, provided s/he does not live in a non-institutional living arrangement between the two periods of institutional living.

Example: Mr. Wunder's niece moved him from his community waiver placement in Bayfield County to an SNF nursing home in Eau Claire County. This is a continuous period of institutionalization. If he had gone to live with his niece for a while, and then gone to the Eau Claire nursing home, his arrival at the Eau Claire nursing home would have been considered a new period of institutionalization.

This page last updated in Release Number : 01-02
Release Date: 04/01/01
Effective Date: 04/01/01

5.10.3 Requirements

All institutionalized persons applying for MA must meet the same nonfinancial requirements. Spousal impoverishment policy introduces no changes in MA nonfinancial tests.

On the financial side:
1. Assets. The assets of both the institutionalized person and his/her spouse are counted in the asset test.
2. **Income.** The income limit is the same as that for non-spousal impoverishment institutionalized persons. But, after the institutionalized person becomes eligible, s/he is allowed to allocate some of his/her income back to his/her community spouse and family.

This page last updated in Release Number: 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

5.10.4 Assets

Count the combined assets of the institutionalized person and his/her community spouse. (Note: Disregard prenuptial agreements. They have no effect on spousal impoverishment determinations.) Add together all countable, available (4.5.1) assets the couple owns.

Do not count the following assets:

1. Homestead property. If the institutionalized person and the community spouse each owns home property and meets the criteria in 4.5.8.1.3, exempt the institutionalized person's home, but not the community spouse's home.

Example: One spouse is in a nursing home, the other lives in the community. They have lived apart for 10 years. The institutionalized person owns a home and intends to return. The community spouse owns a different home. The home that each spouse owns is the principal residence of that spouse. The institutionalized person's home is an exempt asset. The community spouse's home is not exempt.

   If they both own homes and the institutionalized person's home is not exempt, count the institutionalized person's home, but exempt the spouse's home. Both homes cannot be exempt simultaneously.

2. One vehicle, regardless of value or purpose. If the AG has more than one vehicle, disregard one vehicle totally, regardless of value or purpose. Then, for the remaining vehicles, follow the EBD rules for vehicles (4.5.7.9).

3. Any/all assets designated for burial purposes are exempt. The amount should be supported by documentation of the burial related costs or contract. For example, ask the client to document that they have arranged to purchase a $100,000 casket or that a funeral home will provide them with a $75,000 funeral along with an itemized listing of the funeral goods and services that will be provided.

   Do not allow applicants and recipients to simply state that they are setting aside an unreasonable amount of cash (e.g., $1,000,000) as their burial fund for unspecified funeral expenses. If they can document the funeral expense that they expect to incur, it can be totally exempt regardless of its cost.

   This differs from EBD burial policies for non-institutionalized persons and institutionalized persons without a community spouse (4.5.5).

4. Household goods and personal items, regardless of their value.

5. All assets not counted in determining EBD MA eligibility.

6. IRA's of an ineligible community spouse (See 4.5.7.21).

5.10.4.1 Asset Assessment

The ESA must make an assessment of the total countable assets of the couple at the:

1. Beginning of the person's first continuous period of institutionalization of 30 days or more, or

2. Date of the first request for community waivers, whichever is earlier.

Complete an asset assessment using the HCF 10095 "Medicaid Asset Assessment" when someone applies, even if s/he had one done in the past, to get the most current asset share.
If the client was not married on the first date of institutionalization or waivers request, apply the policy from the point s/he is married.

You must also do an asset assessment at any other time the institutionalized person or his/her spouse requests it.

Tell the person for whom you are making the assessment what documentation is required. S/he must document ownership interest in and the value of any available assets the couple had at the time of his/her first period of continuous institutionalization. Use the same documentation procedures used when an application is filed (1.2).

5.10.4.2 Calculate the CSA

The community spouse asset share (CSAS) is the amount of countable assets greater than $2,000 that the community spouse, the institutionalized person, or both, can possess at the time the institutionalized person applies for MA.

IF the total countable assets of the couple are:	THEN the CSAS is:
$190,200, or more	$95,100.00
Less than $ $190,200 but greater than $100,000	½ of the total countable assets of the couple
$100,000 or less	$50,000

CARES will send each member of the couple a letter that states the couple's total countable assets, the CSAS, how much the institutionalized spouse must transfer to the community spouse, the date by which the transfer must be made, and the institutionalized person’s asset limit.

5.10.4.3 Asset Test

When the institutionalized person applies for MA, compare the total countable assets of the couple to $2,000 plus the greater of:

1. CSAS, **or**
2. An amount ordered by a court, or fair hearing.

If assets at the time of application are equal to or less than this amount, the institutionalized person is eligible. If they are more, s/he is not eligible.

5.10.4.4 Undue Hardship

The institutionalized person will not be denied MA if the ESA determines that the ineligibility caused by excess assets creates undue hardship for him/her. Undue hardship means an immediate, serious impairment to the institutionalized person's health.

5.10.4.5 Asset Transfer

After the institutionalized person is found eligible, s/he may transfer assets to the community spouse. The maximum amount s/he can transfer is the CSAS (or a greater amount ordered by a court or a fair hearing). If the community spouse already has some assets, the institutionalized person can transfer assets which when added to the community spouse's assets equal the CSAS (or an amount ordered by a court or a fair hearing).

S/he isn't allowed to transfer assets for less than fair market value to anyone other than the community spouse.

S/he must transfer the assets by the next regularly scheduled review. If his/her assets are above $2,000 on the date of the next scheduled re-view, s/he will be determined ineligible.

Example: Phil is a community waivers participant. He inherits $100,000. He will remain asset eligible as long as he transfers it to his wife. She can do anything she wants with the money except give it away. See 4.7.4.

If s/he leaves the institution for 30 days or more and then becomes institutionalized again as an applicant or recipient, the time allowed to transfer the assets does not start over.

S/he is held to the requirement to transfer assets within 1 year of the date of s/he was first determined eligible for institutional MA.

There is no recovery by MA for MA services already provided if, at the time of the next scheduled review, the institutionalized person is found ineligible because of assets s/he should have transferred.

This page last updated in Release Number : 05-01
Release Date: 01/11/05
Effective Date: 01/01/05

5.10.5 income

The income limit is the same as for institutionalized persons who don't have a community spouse. See 8.1.5.

5.10.5.1 Nontrust Income

Count non-trust income as belonging to the person who receives the payment.

1. If the payment is received in both spouses' names, count half for each.

2. If the payment doesn't specify the payee, count half for each spouse.

3. If the payment is shared with others, count amounts equal to each spouse's proportionate share.

Count as income to the institutionalized spouse any income that the community spouse actually makes available to him/her, whether voluntarily or under a court order.

5.10.5.2 Trust Income

Follow the specific terms of the trust as to which spouse is the payee and what percentage of the income belongs to him/her. If the percentage is unspecified, consider half the payment to belong to each spouse. If any trust income goes to dependent family members, attribute it to whom it is assigned; if it isn't assigned to a specific family member, divide it equally between those who receive it.

This page last updated in Release Number: 04-03
Release Date: 08/02/04
Effective Date: 08/02/04

5.10.6 income allocation

After the institutionalized person is found eligible, s/he may allocate some of his/her income to the community spouse and dependent family members living with the community spouse.

Dependent family members include:

1. Dependent minor children (natural, adopted, step) of either parent who live

with the community spouse.

2. Children (natural, adopted, step), 18 years of age or older, of either parent, who are claimed as dependents for tax purposes under the Service Code Internal Revenue (IRSC) and who live with the community spouse.

3. Siblings of either the institutionalized person or the community spouse who are claimed as dependents and who live with the community spouse.

4. Parents of either the institutionalized person or the community spouse who are claimed as dependents and who live with the community spouse.

The institutionalized person must decide how much income to allocate. S/he may allocate an amount that brings the community spouse's and family members' income up to the maximum allocation, or s/he may choose to allocate a lesser amount.

Since s/he may have medical costs that aren't covered by MA, s/he may wish to keep some income and not allocate it all.

Example 1: Caroline has monthly income of $400. She transfers $310 to her community spouse, keeping only her personal needs allowance (8.1.5.1) and $45 to pay as her monthly patient liability. She incurs $80 in non-covered medical expenses each month. Those expenses will be charged first to her patient liability. But she must pay the remaining $35.00 out of her personal needs allowance. If the personal needs allowance does not cover her expenses, the provider will try to obtain the balance from the community spouse.

Use the Spousal Impoverishment Income Allocation Worksheet (WKST 07) to determine how much of the institutionalized spouse's income:

1. May be allocated to his/her spouse (Section A).

2. Will be deducted, regardless of whether or not s/he actually allocated it to other dependent family members (Section B).

3. Will be paid toward his/her cost of care (Section C).

On the Spousal Impoverishment Income Allocation Worksheet (WKST 07), do the following:

Section A -- Community Spouse Income Allocation

1. Enter on Line 1 the community spouse maximum income allocation. Unless a larger amount is ordered by a fair hearing or court, the maximum allocation is the **lesser** of:

   a. $2,377.50, **o**r
   b. $2,081.67 plus excess shelter allowance.

   "Excess shelter allowance" means shelter expenses above $624.50. Subtract $624.50 from the community spouse's shelter costs. If there is a remainder, add the remainder to $2,081.67.

   Community Waivers. Follow these rules to determine when to add the excess shelter cost to the community spouse income allocation:

   - If the waiver person's community spouse lives with him/her, do not add the excess shelter cost to the income allocation.

   - If the waiver person's community spouse does not live with him/her, add the excess shelter cost to the income allocation.

     Community spouse shelter costs include the community spouse's expenses for:

     i. Rent.
     ii. Mortgage principal and interest.
     iii. Taxes and insurance for principal place of residence. This includes renters insurance.
     iv. Any required maintenance fee if the community spouse lives in a condominium or cooperative.
     v. The standard utility allowance established under the Food Stamp program:

If Community Spouse pays:	**Add**
Heat and utilities	$238
Utilities only	$135
Telephone only	$24
If the community spouse lives in a condominium or cooperative where the maintenance fee includes utility expenses, reduce the standard utility allowance by the amount of utility expenses included in the maintenance fee.	

A court or fair hearing can increase the community spouse income allocation if it determines the spouse is not able to provide for his/her necessary and basic maintenance needs with the amount allocated.

If a court or a fair hearing decision orders a larger Community Spouse Income Allocation, enter the court or fair hearing ordered amount on Line 1.

2. Enter on Line 2 the community spouse's monthly gross income. Use the EBD income rules, but do not give earned income, unearned income, and work related deductions.

3. Do the math from Line 1 through Line 3. The result on Line 3 is the maximum amount of income the institutionalized spouse may allocate to his/her community spouse.

If the institutionalized spouse does not allocate the maximum amount, the amount s/he retains counts as income in determining the amount contributed to the patient liability.

Section B -- Family Member Income Allowance

Enter $520.42 on Line 1 under the name of each dependent family member who lives with the community spouse.

Enter the gross monthly income of each dependent family member under his/her name. Use the EBD income rules, but do not give earned income, unearned income, and work related deductions.

Do the math from Line 1 through Line 3.

Add the Line 3 amounts together and enter the total on Line 4. Deduct the amount on Line 4 from the institutionalized spouse's income.

Section C -- Cost of Care

Enter the institutionalized person's gross monthly income on Line 1. Use the EBD income rules, but do not give earned income, unearned income, and work related deductions.

Enter his/her personal allowance on Line 2:

Personal Needs Allowance (8.1.5.1) for a person in a medical institution, or

Personal Maintenance Allowance for a person in community waivers. This is the Community Waivers Basic Needs Allowance (8.1.5.1) plus other applicable deductions (5.9.9.2.1) up to the EBD Maximum Personal

Maintenance Allowance amount (8.1.5.1).

3. Enter on Line 4 the income allocation amount (Section A, Line 3) that is actually allocated to the community spouse.

4. Enter on Line 6 the dependent family member allowance from Section B, Line 4.

5. Enter on Line 8 any court-ordered guardian or attorney fees (5.8.6.5).

6. Community waivers only. Enter on Line 10 the community waiver person's medical/remedial expenses and the cost of his/her health insurance premiums.

   Nursing home cases only. Enter on Line 10 the cost of the nursing home person's health insurance premiums.

7. Do the math from Line 1 through Line 11. The result on Line 11 is the amount the institutionalized spouse must pay toward cost of care.

Example 2: Harry, a MA recipient, resides in a nursing home. He has unearned income of $3,600 a month. His wife, Edith, gets $200 a month from Social Security. Her sisters, Mabel and Maxine, whom she claims as dependents on her IRS tax forms, live with her. Mabel has no income. Maxine receives $20 a month from her son.

Community Spouse Income Allocation

Harry's community spouse, Edith, has shelter costs of $756.00 a month. Her excess shelter costs are $756.00 minus $624.50 = $131.50. $131.50 plus $2,081.67= $2,213.17. $2,213.17 is less than $2,377.50, so the maximum allocation amount to Harry's spouse is $2,213.17.

$ 2,213.17 (maximum income allocation)
-200.00 (Edith's monthly income)
$ 2,013.17 (spousal income allocation)

Family Member Income Allowance

$ 520.42 (maximum income allowance)
-0.00 (Mabel's income)
$ 520.42 (Mabel's income allowance)

$ 520.42 (maximum income allowance)
-20.00 (Maxine's income)
$ 500.42 (Maxine's income allowance)

$520.42 (Mabel's income allowance)
+$500.42 (Maxine's income allowance)
$ 1,020.84 (total family member income allowance)

Payment Toward Cost of Care

$ 3600.00 (Harry's income)
-45.00 (personal needs allowance)
-2013.17 (spousal income allocation)
-1020.84 (family member income allowance)
$ 520.99 (nursing home liability amount)

This page last updated in Release Number : 05-01
Release Date: 01/11/05
Effective Date: 10/01/04

5.10.7 effective date

This income allocation policy applies to persons who:

1. Were institutionalized persons (5.10.2.2) on or after September 30, 1989. Disregard the length of time they were already institutionalized.

Example 1: John had been continuously institutionalized for 23 years on September 30, 1989. Apply the income allocation policy to John.

Example 2: Mildred has been continuously institutionalized since September 30, 1989. Apply the income allocation policy to Mildred.

Example 3: George lived in the community most of the time, but he was frequently institutionalized for short periods. He was in a continuous period of institutionalization on September 30, 1989. Apply the income allocation policy to George.

2. Became institutionalized persons (5.10.2.2) on or after September 30, 1989 and were eligible for MA on the date of admission. The date of admission is the effective date for these persons.

Backdating: When requested by the client, test for MA eligibility in the three months prior to the application month. Apply the MA policies in effect during the backdate period. For backdate months, do not deduct the spousal income allocation amount from the institutionalized person 's income unless it was actually transferred to the community spouse in the backdate period. Calculate the income amount and the dependent family member income allocation in the same way as for current months.

This page last updated in Release Number : 03-02
Release Date: 04/01/03
Effective Date: 03/01/03

5.10.8 Community spouse Support Obligation

If it appears the community spouse is trying to avoid his/her support obligation by not signing the application, refer the case to your corporation counsel. § 49.90 Wis. Stats. requires the spouse of a dependent person to contribute to his/her maintenance.

Make a referral also when the community spouse's income is above the maximum income allocation in a spousal impoverishment case. The community spouse is obliged to report changes in his/her income and that of family members.

This page last updated in Release Number: 03-02
Release Date: 04/01/00
Effective Date: 03/01/03

5.10.9 notices

After the institutionalized person has been determined MA eligible, the following notices are sent to both spouses:

1. Notice of Medicaid Income Allocation (HCF 10097). This notice contains the amount of income allocated to the community spouse, and the amount of the institutionalized person's cost of care contribution.

2. Medicaid Recipient Asset Allocation Notice (HCF 10098). This notice specifies the amount of assets the recipient must transfer to the community spouse in order to retain MA eligibility. It also specifies the date by which the transfer must be made.

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 03/01/03

5.10.10 Community Spouse's MA ApPlication

Community spouses who apply for MA must apply on a separate application from that of the institutionalized person. Count assets and income allocated and transferred to them by the institutionalized person when you are determining the community spouse's MA eligibility. Beyond these, count only the assets and income belonging to the community spouse.

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 03/01/03

5.11 SPECIAL STATUS MA

5.11.1 "503" Eligibility

Federal law requires that the Economic Support Agency (ESA) provide Medicaid (MA) eligibility to any applicant for whom the following two conditions exist:

1. S/he is receiving Old Age Survivors Disability Insurance (OASDI).

2. S/he was receiving Supplemental Security Income (SSI) concurrently with OASDI, but became ineligible for SSI.

Note: The notion "**concurrent**" includes situations in which OASDI eligibility is granted retroactively for months in which the person was also receiving SSI. On the other hand, "concurrent" does not include situations in which SSI eligibility is granted retroactively for a period in which the person was also receiving OASDI benefits.

Example: Elmo Tanner was receiving SSI in February, 1996, the month he had a disabling accident. In February, after the accident, he applied for OASDI. In April, 1996, SSA notified him that he had been determined disabled. The notice informed him that his OASDI eligibility extended back to the onset date of his disability in February, 1996. Along with the notice was a check for retroactive OASDI benefits back to the February date. The amount of the OASDI check made him immediately ineligible for SSI. There was no period of time when he was actually receiving both SSI and OASDI benefits at the same time. Nevertheless, Elmo meets the requirement of concurrently receiving both SSI and OASDI benefits from February through April.

On the other hand, if Elmo had been receiving OASDI benefits, and was then granted retroactive SSI benefits for the same period, he would not meet the definition of "concurrent."

An assistance group (AG) with these two characteristics is often referred to as a "503" AG. The name comes from Section 503 of the Medicaid Law.

5.11.1.1 Identifying a "503" AG

When a "503" AG applies for MA, disregard all OASDI COLAs the AG has received since the **last** month s/he was eligible for and received both OASDI and SSI benefits.

To identify a "503" AG, do the following:

1. Ask him/her whether, after April 1977, there has ever been a month in which one of the following conditions existed:

   a. Was eligible for both OASDI and SSI, **or**

   b. Received an OASDI check or a retroactive OASDI check and a SSI check for the same month in which s/he was eligible for both OASDI (or retroactive OASDI) and SSI.

   If s/he says "no", s/he is not a "503" AG. If s/he says "yes" and is no longer receiving SSI, do the following:

2. Ask if s/he is now receiving an OASDI check. If s/he is not, s/he is not a "503" AG. If s/he is, s/he is a "503" AG. Enter “Y” on screen ANPS. S/he will receive a COLA disregard.

   If s/he was receiving SSI-E, the state SSI-E Supplement (8.1.5) will also be deducted.

   SSI-E AGs are SSI recipients who receive a higher state supplement than regular SSI. Persons who receive SSI-E payments must live:

   a. In substitute care of eight or fewer beds, **or**

   b. At home and need more than 40 hours a month of primary long term support services.

5.11.1.2 Calculating the COLA Disregard

To calculate the Cost-of-Living Adjustment (COLA) disregard amount, do the following:

1. Find the AG's current gross OASDI income. The gross OASDI income is the amount of the OASDI check plus any amount that has been withheld for a Medicare premium plus any amount withheld to repay an earlier overpayment.

   Do not include in the gross income any Medicare Plan B premiums, which the State has paid for the AG.

2. On the COLA Disregard Amount Table (8.1.7) find the last month in which the person was eligible for and eligible for and received a check for both OASDI (or retroactive OASD I) and SSI.

3. Find the decimal figure that applies to this month.

4. Multiply the person's current gross OASDI income by the applicable

decimal figure. The result is the COLA disregard amount.

> **Example**: Newby's current gross OASDI income is $700. He is not currently receiving SSI benefits. The last month in which he was eligible for both OASDI and SSI, and received benefits from both was April 1991. On the COLA Disregard Amount Table (8.1.7), April 1991 falls between January 1991 - December 1991.
>
> Therefore, the decimal figure that applies to April 1991 is 0.262741. Multiply 0.262741 x $700 to find Newby's COLA disregard amount.

Periods of MA ineligibility do not affect this disregard. When the person reapplies, give the disregard again.

This page last updated in Release Number : 03-03
Release Date: 09/22/03
Effective Date: 09/22/03

5.11.2 Disabled Adult Child (DAC)

A Disabled Adult Child (DAC) is:

1. At least 18 years old at the time SSI was lost.

2. Classified by the Social Security Administration as disabled before age 22.

3. Receives an OASDI (DAC) payment that is based on the earnings of a parent who is disabled, retired, or deceased.

4. Was receiving SSI, but lost SSI eligibility because the OASDI (DAC) payment exceeded the SSI income limits.

5.11.2.1 DAC Payment Disregard

When a Disabled Adult Child applies for MA, disregard all OASDI (DAC) payments which caused him/her to lose SSI eligibility.

> **Example 1:** George is an SSI recipient. While his father worked, George received a monthly SSI payment of $635.78.   When his father retired and began receiving $1000 a month in social security, George began receiving an OASDI (DAC) payment of $500 a month (50% of his father's social security payment). His monthly check is $635.78 ($500 DAC + $135.78 SSI + $20 SSI unearned income disregard).
>
> When George's father dies, George begins receiving a DAC payment of $750 a month (75% of his father's social security payment). This puts him over the SSI income limit ($553.78 + $20 unearned income disregard = $573.78). He loses SSI.

When he applies for EBD MA, disregard the total increase of $250 ($750 - $500 = $250).

Example 2: Harvey is an SSI recipient. While his father works, Harvey receives a monthly SSI payment of $635.78. When his father retires and receives $1800 per month in social security, Harvey begins receiving an OASDI (DAC) payment of $900 (50% of his father's Social Security payment). This $900 payment makes Harvey ineligible for SSI.

When Harvey applies for EBD MA, the initial DAC payment of $900 will be disregarded when his EBD MA eligibility is determined.

Periods of MA ineligibility do not affect this disregard. When the person reapplies, give the disregard to him/her again.

5.11.2.2 COLA Disregard

When a Disabled Adult Child applies for MA, disregard all OASDI COLAs since the last month s/he was eligible for and received both OASDI and SSI benefits. Calculate the COLA disregard amount (5.11.1.2).

If the Disabled Adult Child was receiving SSI-E, disregard both the state SSI-E Supplement (8.1.5) and the COLA.

Periods of MA ineligibility do not affect this disregard. When the person reapplies, give the disregard to him/her again.

This page last updated in Release Number : 03-03
Release Date: 09/22/03
Effective Date: 09/22/03

5.11.3 Widows & Widowers

A widow or widower who lost SSI remains eligible for MA if s/he meets all of these conditions:

1. Disabled.
2. Age 50 or older.
3. Either:

a. Married to the deceased person at time of his/her death, **or**

b. Married to deceased at least ten years, divorced from him/her, and now unmarried.

4. Receiving OASDI benefits as widow or widower (Section 202, Title II, Social Security Act).

5. Received SSI or a State Supplementary Payment (SSP) (8.1.5) in the month before the month in which s/he began to receive OASDI payments.

6. Became ineligible for SSI or SSP.

7. Would be eligible for SSI or SSP except for the receipt of the OASDI payment. Disregard the entire OASDI amount.

8. Not entitled to Medicare Part A.

This page last updated in Release Number: 03-01
Release Date:01-01-03
Effective Date: 01-01-03

5.11.4 MA Deductible, Cost of Care

When you are calculating a MA deductible, a patient liability amount, a community waivers cost share or a community waivers spenddown for a "503" AG, a DAC, or a widow or widower, use the total income before any COLAs or OASDI (DAC or widow/widower) increases were subtracted.

This page last updated in Release Number: 03-01
Release Date:01-01-03
Effective Date: 01-01-03

5.11.5 1619 Cases

Section 1619 of the Social Security Act applies to severely impaired persons who work. If they would be ineligible for SSI because of their earnings, they keep their SSI MA eligibility.

1619(a) - They are working individuals who continue to receive a small SSI check. They retain SSI MA eligibility.

1619(b) - They are working individuals who do not receive a SSI check but are still eligible for SSI MA. For the COLA disregard determination, use the date cash payments ended.

To determine the person's SSI status, contact the local Social Security Office. Social Security processes MA eligibility for these clients.

The SSI benefits of a 1619 person entering an institution continue for up to two months.

If a client loses 1619 status, but also is a widow/widower, DAC, or 503, s/he is entitled to all disregards that are appropriate for these special status cases when determining eligibility. Losing 1619 status is considered the same as losing SSI eligibility.

This page last updated in Release Number: 03-01
Release Date:01-01-03
Effective Date: 01-01-03

5.11.6 Katie Beckett

The Katie Beckett program tests qualified blind and/or disabled minors for MA. It does not deem assets and income from the natural or adoptive parents.

To qualify under the Katie Beckett program a blind or disabled minor:

1. Must require a level of care provided in a hospital, Skilled Nursing Facility (SNF), or Intermediate Care Facility (ICF), and

2. Can appropriately receive this care in his/her home, and

3. Would be non-financially eligible for MA if s/he were in a hospital, SNF, or ICF.

If a minor child meets these requirements and if the parent wants him/her to remain in the home, contact:

Katie Beckett Program
Division of Supportive Living Services
Bureau of Developmental Disabilities
1 West Wilson Street, Room 418
Madison, WI 53707
Telephone (608) 266-3236

This page last updated in Release Number : 03-01
Release Date:01-01-03
Effective Date: 01-01-03

5.11.7 Tuberculosis

MA applicants who are infected with tuberculosis (TB) are non-financially eligible for TB-related MA services.

5.11.7.1 Non-Financial Requirements

Consider these persons to be in a special category of MA. They are non-financially eligible for TB-related MA if they are infected with TB, even if they are not blind, disabled, or over age 65. “Infected with TB” means that a physician has examined them and found that one or more of the following diagnoses apply to them:

1. Infected with latent or active TB.

2. Positive TB skin test.

3. Negative TB skin test, but a positive sputum culture for the TB organism.

4. Negative test for TB, but a physician certifies that they require TB-related drug therapy or surgical therapy or both.

5. A physician certifies that they require testing to confirm the presence or absence of TB.

Accept the client’s statement that they have one or more of the above conditions unless the information provided is questionable (1.2.4). If questionable, accept any of the following as verification:

1. A physician's or registered nurse's written confirmation that the person has one or more of the above conditions.

2. Wisconsin Tuberculosis Record (Form DPH 4756). This card identifies the person and the physician's diagnosis, and has on it the name and telephone number of the treatment provider.

5.11.7.2 Financial Tests

Assets. The asset limit for one person is $2,000. Count assets the same as for other EBD AGs.

Income. The income limit for one person is $1,243. This is gross income. There is no net income test.

Deductible. TB-related AGs which fail the TB-related gross income test cannot become eligible for a MA deductible.

If more than one person in the AG is TB-infected, test each person as a single individual with his/her own fiscal test group. Do not deem assets or income from any other member of the AG.

Example 1: Mary and her spouse George are both applying for TB-related MA. Test Mary and George as separate fiscal test groups. Do not deem assets or income from Mary to George or from George to Mary. Test Mary's assets against the asset limit. Test her income against the income limit for one person. Test George's assets against the asset limit. Test his income against the income limit for one person.

Example 2: There are three children in the Kraan family. All of the children have TB. Consider each child to be a separate fiscal test group. Test each child using only his/her own assets and income. Each child's assets do not exceed the asset limit (5.11.7.2). Each child's income limit does not exceed the income limit (5.11.7.2). Do not deem assets or income from the child's parents or from any of his/her siblings.

If only one person in the AG is TB-infected, and that person is a:

1. TB-infected minor or 18-year-old.

   Test him/her in the Financial Tests for Disabled Minors (1.1.3.1.2). Add the parents' deemed assets and income to the minor or 18- year-old's assets and income. Test him/her against the asset limit and the gross income limit.

2. TB-infected adult with assets/income, and spouse with no assets/income.

   Test the TB-infected adult's assets/income against the asset limit and the gross income limit.

3. TB-infected adult with assets/income, and spouse with assets/income.

   Use the EBD-Related Determination Worksheet (WKST 06) to determine the spouse's assets and net income. Add these totals to the TB-infected person's assets and gross income. Compare this total to the asset limit and the gross income limit.

4. TB-infected adult with no assets/income, and spouse with assets/income.

   Use the WKST 06 to determine the spouse's assets and net income. Compare these results to the asset limit and the gross income limit.

   When using the WKST 06, disregard items 16-18. Replace item 19 with the TB-related income limit. Disregard item 20.

5.11.7.3 TB-Related Services

Persons who become eligible for TB-related MA receive an MA card that identifies them as eligible for only the following MA services:

1. Prescribed drugs.

2. Physicians' services.

3. Laboratory and X-ray services, including services to diagnose and confirm the presence of infection.

4. Clinic services and federally qualified health care (FQHC) services.

5. Targeted case management services.

6. Services, other than room and board, designed to encourage completion of regimens of prescribed drugs by outpatients.

7. Services that are necessary as a result of the side effects of prescribed drugs for TB treatment.

5.11.7.4 QMB, SLMB and QDWI

QMB, SLMB, and QDWI recipients do not automatically qualify for TB-related MA services. If they are eligible for EBD or Family MA, they can receive TB-related services under regular MA.

5.11.7.5 Aliens

TB-related services are included among emergency services for persons who do not meet citizenship requirements (3.2.2).

5.11.7.6 Processing

Determine TB-related AGs manually in the following way:

1. Determine MA eligibility for all other subprograms in CARES. Do not confirm unless there is eligibility for a category of MA that is not QMB, SLMB, or QDWI.

   If there is only QMB, SLMB, or QDWI eligibility, test the person against the TB-related financial tests. Complete and return a HCF 10110 (formerly DES 3070) to EDS:

   a. Mail: EDS
      P.O. Box 7636
      Madison, WI 53707

   b. E-mail: eds_3070@dhfs.state.wi.us

   c. Fax: (608) 221-8815

2. If the client is eligible, certify him/her with a manual HCF 10110 (formerly DES 3070) form, medical status code of TR. Confirm all denials in CARES and allow the CARES generated notices to be sent. Send him/her a manual positive notice with the effective date of his/her eligibility for TB-related services.

3. If the person is not eligible for any MA subprograms, including TB-related MA, confirm all denials in CARES and allow the CARES generated notices to be sent. Send him/her a manual negative notice indicating that s/he is not eligible for TB-related MA.

This page last updated in Release Number : 05-01
Release Date: 01/11/05
Effective Date: 01/01/05

5.11.8 Migrant Workers

"Migrant worker" means any person who temporarily leaves a principal place of residence outside of Wisconsin and comes to Wisconsin for not more than ten months in a year to accept seasonal employment in the planting, cultivating, raising, harvesting, handling, drying, packing, packaging, processing, freezing, grading or storing of any agricultural or horticultural commodity in its unmanufactured state. "Migrant worker" does not include any of the following:

1. A person who is employed only by a state resident if the resident or the resident's spouse is related to the person as the child, parent, grandchild, grandparent, brother, sister, aunt, uncle, niece, nephew, or the spouse of any such relative.

2. A student who is enrolled or, during the past six months has been enrolled, in any school, college or university unless the student is a member of a family or household which contains a migrant worker.

A migrant family includes the adults, including non-marital coparents, and their dependent children living in the migrant household.

5.11.8.1 Simplified Application

Use the following simplified application procedure to determine MA eligibility for migrant workers and their families who have come into Wisconsin and who:

1. Have current MA eligibility from another state. ("Current MA eligibility" means eligibility that includes at least months one and two of the application process.) **Or** had MA eligibility in Wisconsin that was certified through months one and two of the application and that ended only because the family left Wisconsin.

2. And have the same members or fewer in the case as there were when the case had eligibility in the other state.

The simplified application procedure is as follows:

1. For clients with current MA eligibility from another state, verify the eligibility and the end date. Accomplish the verification by copying the out-of-state MA card or by contacting the other state.

2. For clients previously eligible in Wisconsin find the CARES closure code and review date.

3. Ask if the same members, or fewer, are in the case compared to when the group was eligible in the other state.

4. Collect all non-financial information.

5. Do not collect any financial information.

6. Certify MA benefits for the migrant family.

Example 1: A migrant family consisting of dad, mom, and their three children comes to Wisconsin. On September 3, 2001, dad applies for MA in Wisconsin for himself and his family.

The family has current MA eligibility from Texas. That is, eligibility extends beyond application months one and two.

The household composition of five members is the same as listed on the MA card.

The fulfillment of these two conditions indicates that the case should be processed with the simplified application procedure.

The ES enters non-financial information into CARES, and completes the asset and income screens by answering "N" to all of the financial questions. S/he also makes sure to answer "Y" to the migrant question on ANDC for all family members.

CARES passes the case for MAOU eligibility with $0 assets and $0 income. The eligibility end date from Texas is November 30, 2001. The ES changes the review date on AGEC to November 30, 2001, to coincide with the end date from Texas.

Example 2: The same migrant family comes in for the November 2001 review. Verify all mandatory and questionable verification items. The family is determined eligible through October 31, 2001.
The family leaves Wisconsin in December, 2001. MA closes for failure to reside in the state. In March 2001, the family returns. There have been no non-financial changes and no changes in household composition. The family should be processed with the simplified application procedure because their case closed only for failure to reside in Wisconsin.

5.11.8.2 Regular Application

If migrant workers and their families have no current MA eligibility, or if there are additional family members who were not eligible in the prior state of residence, process the case as a regular MA application, with the following exception:

Use annualized earned income. “Annualized earned income” is a prospective monthly estimate of earned income based on the estimated total gross annual earnings divided by 12. Annualized income can be based on the past 12 months of the migrant family’s income if it is anticipated that last year’s income is the best estimate of the current year’s prospective income.

5.11.8.3 Reviews

Offer the following three review choices for migrant families:

1. Mail.
2. Phone.
3. Face-to-face interview.

Income is always annualized.

See 2.2 for information on reviews.

5.11.8.3.1 Simplified Application

For migrant families that have been certified through the migrant simplified application process, the first review coincides with the date out-of-state eligibility ends. The next review is 12 months from the first review.

5.11.8.3.2 Regular Application

For migrant families that have been certified through the regular application process, the first review is 12 months from the month of application.

This page last updated in Release Number: 03-02
Release Date: 04-01-03
Effective Date: 04-01-03

5.12 MEDICAID PURCHASE PLAN (MAPP)

5.12.1 MAPP

The Medicaid Purchase Plan (MAPP) is a subprogram of the Wisconsin Medicaid Program. It allows disabled people who are working or want to work to become or remain MA eligible, even if employed, since there are higher income limits.

This page last updated in Release Number : 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

5.12.2 Application

MAPP was automated in CARES in January 2002. Use CARES to determine and certify eligibility for MAPP.

For months prior to January 2002, use CARES to determine if a client is eligible for a higher subprogram of MA. If not, use the manual worksheet process to determine and certify eligibility for MAPP and to establish a monthly premium (if applicable).

5.12.2.1 Begin Month

Certify applicants for MAPP retroactively for any or all, up to three prior months, if s/he met all of the eligibility criteria at that time. The client is responsible for any premium due for the previous months in which s/he elects coverage.

Clients can also choose to begin MAPP eligibility during any future month that can be processed in CARES.

Example: Jack applies for MAPP on September 30th and requests a retroactive determination of eligibility. His application is processed on October 21st. He meets all eligibility requirements as of June. Jack can choose to begin MAPP eligibility in June, July, August, September, October, November or December.

5.12.2.2 Fiscal Test Group (FTG)

When both members of a married couple (living together) apply for MAPP, each person must be in a separate Assistance Group (AG). Enter them in CARES on the same application. The client's spouse is a countable member of the FTG. A separate financial test is done for each spouse's AG. The married couple is entered on the same case, but they are in two separate AGs.

If a spouse of a MAPP applicant chooses not to disclose or verify assets, a case may fail for a higher MA eligibility and still cascade to MAPP eligibility.

If both members of a married couple (living apart) apply for MAPP, determine eligibility as two separate cases.

Include the client's spouse and test children in the FTG. Test children include the client's minor natural or adoptive children. Do not include the client's stepchildren in the FTG. Do not count the income or assets of the test children.

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

5.12.3 Non-Financial Requirements

Clients must meet all of the following:

1. Meet general MA non-financial requirements (1.1.2),

2. Be at least 18-years-old, (there is no maximum age limit).

3. Be determined disabled, presumptively disabled, or MAPP disabled by the Disability Determination Bureau (DDB) (3.6.9), **and**

4. Be working in a paid position or participating in a Health and Employment Counseling (HEC) program (5.12.3.4).

5.12.3.1 Disability

DDB must certify disability (3.6.9). There is no requirement that a client be a current or former SSI or SSDI beneficiary to qualify for MAPP. Earned income is not used as evidence in MAPP disability determinations.

If a client does not have a disability determination from SSA, refer the client to the DDB for a disability determination. Send a Medicaid Purchase Plan Transmittal of Medicaid Disability Application (HCF 10120) to identify a client who has applied for MAPP and needs a disability determination. The rest of the MAPP application may be completed at this time, however, a client cannot be eligible for MAPP until the disability determination has been made. Pend the case in CARES while you are waiting for a MAPP disability determination from DDB.

Follow the rules in section 3.6.6 on when to review disability determination.

5.12.3.2 Work Requirement

To meet the work requirement, a client must engage in a work activity at least once per month, or be enrolled in a Health and Employment Counseling (HEC) program (5.12.3.4). Consider a client to be working whenever s/he receives something of value as compensation for his/her work activity.

This includes wages or in-kind payments. The exceptions are loans, gifts, awards, prizes, and reimbursement for expenses.

5.12.3.2.1 Self-Employment

If a client engages in a self-employment activity that generates some compensation, at least once in the calendar month, the individual is employed for purposes of MAPP.

A client does not need to realize a profit from self-employment for it to be defined as work.

5.12.3.2.2 Contractual Employment

If an individual is under contractual employment for the entire year, s/he is employed for the purposes of determining MAPP eligibility for the entire year. Do not consider clients employed for any months in which they do not have a contractual employment agreement.

5.12.3.2.3 Employment Ending

A client has until the last day of the next calendar month to become employed again. Do not take action to terminate eligibility until one full calendar month has passed since employment ended.

5.12.3.2.4 Temporary Employment

If a client has signed up with a temporary service agency and is not actually working, s/he is not working for purposes of MAPP. If a client is engaged in work activity for which compensation will be received, at least once in a calendar month, s/he is employed for the purposes of determining MAPP eligibility in that calendar month.

5.12.3.3 Work Requirement Exemption

If there is a serious illness or hospitalization that causes the client to be unable to work, the work requirement can be suspended for up to six months. S/he can continue to be MAPP eligible. The client must contact the ESA to request the exemption. Have the client complete the Medicaid Purchase Plan (MAPP) Work Requirement Exemption (HCF 10127). This provision is not available unless s/he:

1. Has been enrolled in MAPP for six months and has paid any applicable premiums prior to the request of an exemption.

2. Is expected to return to work in the next six months.

3. Provides an expected date of recovery.

4. Provides the reason that an exemption is needed (i.e., illness or hospitalization).

5. Has had no more than two exemptions (maximum of six months each) to the work requirement in a three-year time period.

Based on criteria outlined above, the ESA will approve or deny the request. If a work exemption request is denied, the client has appeal rights in accordance with the MA program.

In the sixth month of an exemption, mail to the recipient a notice indicating the date the Medical Work Exemption will end as well as steps the client may take to continue MAPP eligibility.

5.12.3.4 Health and Employment Health and Employment Counseling Program (HEC)

Health and Employment Counseling Program (HEC) is a program certified by the Department of Health and Family Services (DHFS) to arrange services that help a client reach his/her employment goals. HEC participation can occur for up to nine months with a three-month extension, for a total of 12 months. After six months a client can re-enroll in HEC to meet the eligibility criteria for MAPP, as long as they have not already participated two times within a five-year period. HEC participation is limited to twice within a five-year period, and there must be six months between any two HEC participation periods.

Clients who are not working can meet the MAPP work requirement if participating in a HEC program. If an applicant is not currently working and wants to meet with a HEC screener, pend the case for up to 30 days beyond the application processing period. For an ongoing case, pend the case for up to 30 days after the change is reported or eligibility review is completed. This allows time for the screener to determine if the person qualifies for HEC.

If a determination has not been provided by the HEC screener within the thirty days, deny the case. The client is responsible for reporting HEC participation to the ESA. The ESA is not responsible for tracking HEC participation.

5.12.3.4.1 HEC Processing

Give the client a blank MAPP Employment Plan form, a Medicaid Purchase Plan factsheet (PHC 10071) , and the list of HEC screeners in your area. The client needs to complete the Employment Plan and give it to the screener.

The screener and client meet to set employment goals. The screener approves or disapproves the Employment Plan and then sends it to the Department of Health and Family Services (DHFS) MAPP Unit, where a final approval/disapproval decision is made within ten working days. Their address is:

Pathways to Independence
Room 1150
1 W. Wilson St
Madison, WI 53701

If the plan is not approved, the client should be informed by the HEC counselor that s/he has appeal rights and has the right to file a fair hearing.

The DHFS MAPP Unit sends an approval letter to the client and the screener. In order to receive MAPP, the client is responsible for providing ESS with a copy of the approval letter.

See 5.12.10. HEC Regional Screeners for a listing.

5.12.3.4.2 HEC Extension

A participant can extend a HEC period by contacting HEC to request an extension.

If the HEC period is ending prior to the client meeting his/her employment plan goals, but the goals can be met within the three months after the regular HEC period will end, the DHFS MAPP Unit can extend the HEC participation for three months.

5.12.3.4.3 HEC Participation Changes

The HEC counselor/screener monitors the participation of the client as s/he pursues the goals described in his/her MAPP Employment Plan. Whenever a client notifies you that s/he has stopped participating in the HEC program, terminate eligibility with adverse action notice.

Whenever a HEC participant notifies you that s/he is now employed, gather information about the employment and redetermine eligibility.

5.12.3.5 Health Insurance Premium Payment (HIPP)

See 6.3.7 for information about Health Insurance Premium Payment (HIPP) and cooperation requirements.

5.12.3.6 Spousal Impoverishment

There are no spousal impoverishment protections for MAPP. An institutionalized client who was determined ineligible for MA using the MA Institutions tests can qualify for MA through MAPP. However, because we only count the client's assets in determining MAPP eligibility, we do not apply the spousal impoverishment provisions for assets. Similarly, because we do not have a post-eligibility treatment of income and instead calculate a premium using only the client's income, there is no community spouse income allocation or family member maintenance allowance for MAPP.

5.12.3.7 Institutionalization

Clients in an institution may qualify for MAPP if they fail institutional MA. If the client's income exceeds 150% of the FPL (8.1.6), s/he is responsible to pay a monthly premium instead of a patient liability or cost share (5.8.7) and (5.8.7.3).

5.12.3.8 Community Waivers

MAPP is a full-benefit MA subprogram for community waiver participation (7.1.2). If the client's monthly income exceeds 150% of the FPL (8.1.6), s/he is responsible to pay a monthly premium instead of a cost share.

5.12.3.8.1 Special Managed Care Programs

MAPP clients are eligible for enrollment into specific Special Managed Care Programs (SMCP).

This page last updated in Release Number : 05-01
Release Date: 01/11/05
Effective Date: 01/11/05

5.12.4 Financial Requirements

Follow EBD rules in Chapters 4.1 and 4.5 to determine countable assets and income. The following are MAPP financial eligibility requirements.

5.12.4.1 Assets

Total countable assets of the client must be $15,000 or less.

5.12.4.1.1 Independence Accounts

Someone who has been determined eligible for MAPP can establish an Independence Account. These accounts are an exempt asset. There is no limit to the number of accounts, and no restriction on what the money can be used for.

Only assets deposited while MAPP eligible may be exempted. Deposits made between periods of MAPP eligibility are not exempt.

Example: Freda creates an Independence Account out of an existing pension account in January with a pre-existing $5,000 when she becomes MAPP eligible. In March, while MAPP eligible Freda deposits another $2,000 in her Independence Account. Freda became MAPP ineligible in April and deposited another $1,200 in her Independence Account. Freda became MAPP eligible again in July. In the second period of MAPP eligibility the Independence Account pre-amount would change from $5,000 to $6,200. The only assets that can be exempted are the deposits made while MAPP eligible. In this case $2,000 would be exempt and $6,200 would be counted as an asset.

To qualify as an Independence Account, it must be:

1. Registered with the ESA.
2. A separate financial account owned solely by the MAPP client.
3. Established after MAPP eligibility is confirmed, with the exception of pension and retirement accounts (5.12.4.1.3).

A client's deposits (earned or unearned) in an independence account may total up to 50% of gross earning over a 12-month period, without penalty. If the client's deposits, from actual (earned or unearned income), exceed 50% of his/her actual gross earnings over the same twelve-month period, a penalty is assessed (5.12.5.1.1). Amounts withdrawn from a MAPP Independence Account during a twelve month period do not affect the limit on the gross amount that may be deposited during the same period without penalty.

Example 1: Fred earns $5000 gross from January - December 2003. Total deposits into the independence account were $3000 for the same period. A $500 withdrawal was made in December 2003 to pay for car repairs. The $500 withdrawal is ignored when determining the penalty. The penalty is based solely on total deposits which exceeded 50% of gross earnings over a twelve month period. The result in this example would be a $500 penalty. See (5.12.5.1.1)

5.12.4.1.2 Independence Account Exemption Status

If a client with an approved Independence Account loses MAPP eligibility, the exempt portion of the account (on the date eligibility ends) is exempt for future MAPP application(s). The entire balance is a countable asset for all other MA subprograms.

5.12.4.1.3 Pension or Retirement Accounts

A client who has a pension or retirement account can designate that account as an Independence Account. The initial balance is a countable asset (4.5.7.21). Any dividends, interest, and deposits to the account are exempt from the date the Independence Account is approved. Continue to count the initial balance as an asset.

5.12.4.2 Income

The spouse and client's net income must not exceed 250% of the FPL 8.1.6 for appropriate fiscal test group size. To determine this, do the following:

1. Determine family earned income. Count the client and his/her spouse's income if residing together.

2. Deduct the $65 and ½ of the earned income disregard from the spouse and client's earnings (4.1.3.6).

3. Deduct the client's IRWEs (4.1.3.4). The result is the adjusted earned income.

4. Determine unearned income. Count the client and his/her spouse's income if residing together.

5. Add the adjusted earned and unearned income together.

6. Deduct $20 from the combined income.

7. Deduct special exempt income (4.1.3.2).

8. If a MAPP client receives Social Security payments, subtract the current COLA disregard between January 1st and the date the FPL is effective in CARES for that year.

Example: Ed's Social Security payment amounts were $875 a month for the previous year and $900 for the current year. Calculate the current COLA disregard by subtracting the Ed's previous Social Security payment amounts from the current payments. Allow $25 as the current COLA disregard.

9. Subtract the historical COLA Disregard Amount (4.1.7) for MAPP clients who are also determined to be a 503 (5.11.1) or Disabled Adult Child (DAC) (5.11.2). Do not allow the historical COLA disregard amount (8.1.7) in the premium calculation for MAPP clients who are also determined to be a 503 (5.11.1) or a DAC (5.11.2).

10. Compare the result to 250% of the FPL (8.1.6). Include the client's minor dependent children (natural or adoptive) when determining fiscal test group size. Do not include the client's stepchildren in the fiscal test group size.

This page last updated in Release Number : 05-01
Release Date: 01/11/05
Effective Date: 01/11/05

5.12.5 Premiums

5.12.5.1 Calculation

Calculate premiums using only client income. Calculate a premium if gross monthly amount exceeds 150% of FPL (8.1.6) for the appropriate fiscal test group size.

Steps to calculate monthly premium amount:

1. From gross monthly unearned income, subtract the following:

    a. Special Exempt Income (4.1.3.2).

    b. Standard Living Allowance (8.1.5.1).

    c. Impairment Related Work Expenses (IRWE). For MAPP, use only anticipated incurred expenses, past medical expenses are not allowed. (4.1.3.4).

    d. Medical Remedial Expenses (MRE). For MAPP, use only anticipated incurred expenses, past medical expenses are not allowed. (4.1.3.3)

    e. Current COLA Disregard from January 1st through the date the FPL is effective in CARES for that year. 503, DAC, widow/widower disregards allowed in eligibility determinations can not be allowed in premium calculations.

    The balance is the **Adjusted Countable Unearned Income**. This number may be a negative number.

2. From gross monthly earned income, subtract any remaining deductions from #1. If the result from #1 is a negative amount, change it to a positive number. The balance is the **Adjusted Earned Income.**

3. Multiply the adjusted earned income by three percent (.03).

4. Add the results of #3 and #1 together.

5. Compare the result from #4 to the Premium Schedule (8.1.13) to determine monthly premium amount.

5.12.5.1.1 Penalty

If the client puts (earned or unearned) in an amount that exceeds 50% of the actual earnings into an Independence Account, penalize the client using the following formula. At review, look back 12 months and take the:

Total verified Annual Deposits minus 50% of verified annual gross earned income divided by 12 = monthly assessment.

Add this monthly assessment to the premium for the next 12 months of eligibility. Only impose Independence Account penalties if the client is otherwise required to pay a premium.

Example: Brenda deposited $1,200 more than 50% of her actual annual gross earned income in her Independence Account. If Brenda's income exceeds 150% of the FPL (8.1.6) and she is responsible for a monthly premium, add the monthly assessment of $100 to her monthly premium for the next 12 months. If Brenda's income does not exceed 150% of the FPL (8.1.6), do not impose a penalty.

5.12.5.2 Initial Premium

There are no free premium months. Before eligibility confirmation, the client must pay applicable premiums for the initial benefit month and for any backdate months for which the client elects coverage. If determining eligibility in the month after application, the premium for the second month also must be paid before confirming eligibility.

Example 1: Eric applies for MAPP on January 29th, but his application is not processed until February 11th. You determine that he owes a $50 premium per month. Before confirming eligibility, Eric must pay a $50 premium for January and a $50 premium for February.

Example 2: If Eric applies for MAPP on January 29th. Eric is requesting MAPP for February but not January. CARES will not pend the case for February's premium because you are processing it in January. Confirm the case. The Medicaid fiscal agent will pursue collection of the premium for February.

Complete the premium coupon and the Medicaid Purchase Plan (MAPP) Recipient/Premium Information (HCF 10122) for benefit months prior to January 2002. For benefit months beginning January 2002, CARES will send premium information to MMIS, but the ES continues to be responsible for collecting the premium due for initial month(s) and any backdated months for which the client elects coverage. Complete the premium coupon and record receipt of the premium payment in CARES.

Send MAPP premium payments separate from BadgerCare premium payments and other agency funds. Send premium payments to the following address:

Medicaid Purchase Plan
P.O. Box 6738
Madison, WI 53716-0738

5.12.5.3 Payment Information

5.12.5.3.1 Payment Methods

When requested, EDS will provide clients with instructions for choosing the payment method they want. Clients can contact Recipient Services at 1-800-362-3002.

The payment methods are:

1. Direct payment by check or money order.

2. Electronic Funds Transfer (EFT).

3. Wage withholding from each paycheck received. (Unlike Child Support, there is no statutory requirement that the employer participate in premium wage withholding. If the employer decides not to participate, the participant will have to choose direct pay or EFT.)

Provide clients with the MAPP Premium Recipient/Employer Electronic Funds Transfer (HCF 13023) and MAPP Premium Employer Wage Withholding (HCF 13024) forms to allow the client to choose a payment method other than direct payment. Since it takes some time to set up EFT and wage withholding, the client pays directly until EDS informs them otherwise.

5.12.5.3.2 Advance Payments

Clients can make advance payments, but the payment cannot exceed the certification period. If paying in advance, the payments must be the full amount of subsequent month's premiums (no partial month payments). If the income amount changes, recalculate the premium. The client will be notified through CARES that their premium amount has changed. If the premium amount has decreased, EDS will refund any excess premium that was paid. If the premium amount has increased and the premium coupon has not been sent for that month, the client will receive a coupon with the new premium amount. If the premium coupons have already been sent, the client will need to pay the additional amount owed. The client will not receive a coupon for the difference that is owed.

5.12.5.3.3 Refunds

EDS issues refunds if the client:

1. Lost MAPP eligibility and already paid the premium. Refunds will only be given if adverse action notice requirements were met.

2. Overpaid. The client overpaid and the excess cannot be applied to the next month's premium.

3. Retroactive Adjustment. The premium was recalculated and reduced for prior month(s).

4. Requested to close MAPP and already paid the premium.

The client's estate can receive a refund if s/he dies between adverse action and the beginning of the benefit month.

5.12.5.4 Ongoing Cases

Ongoing premium payments are sent to the MAPP Premium Unit. Checks are made out to "Medicaid Purchase Plan." MAPP premiums are due on the tenth of the benefit month, no matter which payment method is chosen. For clients who have chosen 'direct pay' as their payment method, EDS sends out the premium coupon on the 20th of the month before the benefit month. The payment must be received at EDS by the tenth of the benefit month. EFT occurs on the third business day of the benefit month.

5.12.5.5 Late Payments

Cases are treated differently depending on when the late payment is received. The following explains the policy based on those time differences. Clients must pay the payment that closed them, but do not have to pay the following month right away to open, unless the late pay is made after the benefit month.

Example 1: If the client owed a premium for September, and does not pay it until October, then s/he will need to pay both September and October. October eligibility will pend until the payment is received by the agency and recorded in CARES.

Between Due Date and Adverse Action of the Benefit Month
The case will stay open for the benefit month even if no payment is received by the due date. It will close at the end of the benefit month if no payment is received by adverse action (AA) in the benefit month.

Between Adverse Action of the Benefit Month and the Last Day of Benefit Month
If the client pays between AA of the benefit month and the last day of the benefit month, s/he can reopen. Run SFED with dates and confirm.

Example 2: Adverse action is September 16th. Jim's September premium was due September 10th. Jim has not paid his September premium by September 16th. He does pay on September 26th. The case closed effective September 30th. Run with dates to open for October. Then run without dates for November eligibility.

Anytime in Month After the Benefit Month
If the client pays any time in the month after the benefit month, s/he can reopen. S/he must pay the premium that closed them. If they owe a premium for that following month, s/he must pay that premium before CARES will open MAPP. The client must pay you directly (not EDS). You can check with EDS to see if a premium has already been collected for that month.

When you get the payment(s), record the payment in CARES and run SFED for the benefit month and confirm. Then run SFED for the following month, and confirm.

Example 3: Adverse action is September 16th. Jim has not paid his September premium by September 16th. He pays on October 26th. His case closed for October. Jim must pay both the premiums for September and October since they were in arrears before he will open. To reopen it, run SFED for October and confirm. Finally, run SFED for November and confirm. (The November premium is not due until November 10th and does not have to be paid in advance.)

Two Months After the Benefit Month
If the client pays in the second month after the benefit month, it is a non-payment (5.12.5.6).

5.12.5.6 Non-Payment

If a MAPP client does not pay the monthly premium by adverse action in the benefit month, apply a restrictive re-enrollment period (RRP) (5.12.6), unless there is good cause (5.12.6.1). The RRP begins with the first month of closure. If a late payment is received by the end of the month after the benefit month, lift the RRP.

5.12.5.6.1 Insufficient Funds

You will be notified with an 056 “Run SFED/SFEX” alert in CARES if a MAPP client pays the monthly premium through EFT or direct payment by check, and the payment is rejected for insufficient funds. Apply a restrictive re-enrollment period (RRP), unless there is good cause (anything which is beyond the client’s control), and close the case. The RRP begins with the first month after closure. Determine if an overpayment exists and process the overpayment.

5.12.5.7 Opting Out

If a MAPP client chooses to de-request MAPP coverage, or opt out, anytime prior to the beginning of the next benefit month, close the case in CARES for the next possible month. If the case cannot be closed in CARES at the end of the current benefit month, do not impose a RRP. Close the case in CARES. Submit a HCF 10110 (formerly DES 3070) by mail, e-mail or fax.

1. Mail:

   EDS
   P.O. Box 7636
   Madison, WI 53707

2. E-mail: eds_3070@dhfs.state.wi.us

3. Fax: (608) 221-8815

Enter “MAPP OPT OUT” in red in the comment section of the 3070.

> **Example 1:** Sally calls her worker on July 25th to de-request MAPP for August. Since Sally opted out prior to the benefit month Sally should not owe a premium for August. The worker will need to change the request for MAPP on ANMR and “zero” out the premium due for August.
>
> To zero out the premium the worker has to alter the income for the process month. The altered income should be low enough that MAPP still passes with no premium, and high enough that the applicant does not qualify for another MA subprogram. At this point the worker would have to run the eligibility with appropriate dates and confirm the results. A RRP should not be imposed because Sally de-requested August MAPP coverage prior to the beginning of the benefit month.
>
> Her worker must override the RRP on AGRR by entering an override RRP end date using the reason code “SY”, system problem. Change the request for MAPP on ANMR to “N”, and suppress the CARES notice stating that the client’s MAPP eligibility will end August 31st. Send a manual negative notice indicating that the client’s MAPP eligibility ends July 31st.

A MAPP applicant’s decision to “opt out” does not affect other family members eligibility for MA or MA related Programs.

This page last updated in Release Number : 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

5.12.6. Restrictive Re-enrollment Period (RRP)

When a client is placed in a restrictive re-enrollment period (RRP), s/he is ineligible for the next six consecutive months following the closure of MAPP, unless there is good cause (5.12.6.1). After the six consecutive months, the client may regain eligibility if s/he pays all arrears and current premiums. After 12 calendar months, s/he may regain eligibility without paying the past due premiums.

RRPs are tied to non-payment of premiums only. RRPs do not apply to recipients who have not met HEC requirements.

5.12.6.1 Good Cause

The following are good cause reasons for not paying a MAPP premium:

1. Problems with electronic funds transfer.
2. Problems with an employer's wage withholding.
3. Administrative error in processing the premium.
4. Fair hearing decision.
5. Those you determine are beyond the client's control.

This page last updated in Release Number : 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

5.12.7 Changes

The client must report within ten days all changes to income, household composition and allowable deductions. The ES worker should re-determine eligibility as a result of the changes. If it is determined that s/he remains eligible for MAPP and owes a premium, recalculate the premium amount.

5.12.7.1 Reduced Premiums or No Premiums

The effective date of a change that results in a reduced premium or no premium is the month of change or the month of report, whichever is later. If the change results in no premium, you may have to run eligibility with dates in CARES for the month the change occurred or was reported (which ever is later) and any subsequent months as well as for recurring.

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

5.12.8 Prepaid Deductibles

If the client prepaid a deductible and then becomes eligible for MAPP without a premium, s/he can only get a refund of the prepayment if the deductible period has not started. Use the Community Aids Reporting System (CARS) to report the accounting.

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

5.12.9 Notices

CARES will send notices regarding eligibility and premiums for benefit months from January 2002 forward. Continue to send manual positive and negative notices to clients regarding eligibility and premiums for benefit months prior to January 2002.

1. Use the HCF 16015, Medicaid / BadgerCare Manual Positive Notice, when MAPP is approved or the premium decreases.

2. Use the HCF 16001, Medicaid / BadgerCare Manual Negative Notice, when eligibility is denied or terminated or the premium increases.

   Note: The client must be given adverse action notice of any negative action (e.g. premium increase).

Use the following notice text that is applicable to the denial reason. Use §49.472 WIS STATS as the citation for each of the reasons.

You are not eligible for the MAPP because:

1. Your assets exceed the $15,000 asset limit.

2. Your income exceeds 250% of the FPL (8.1.6) for your family size.

3. You have not paid your MAPP premium.

4. You have been determined ‘not’ disabled under MAPP rules by the Disability Determination Bureau.

5. You are not working.

6. You no longer meet the work or HEC participation requirement of MAPP.

This page last updated in Release Number : 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

5.12.10 HEC Regional Screeners

Organization	Counties
Benefacts, LLC Contact: Mary Krueger Phone: 920-642-3456 or 866-309-3456 Email: mjfred@vbe.com	Brown, Calumet, Door, Florence, Fond du Lac, Green Lake, Kewaunee, Manitowoc, Marinette, Marquette, Oconto, Outagamie, Sheboygan, Waupaca, Waushara, Winnebago

Benesense Contact: Pam Busche Phone: 800-386-6249 Email: pbusche@wolfnet.net	Adams, Forest, Langlade, Lincoln, Marathon, Menominee, Oneida, Portage, Price, Shawano, Taylor, Vilas, Wood
CILWW Contact: Jill Thurow** Phone: 715-233-1070 or 800-228-3287 Email: thurow@cilww.com North Country Independent Living Contact: Scott Anderson* Phone: 715-392-9118 or 800-924-1220 Email: ncilscot@cpinternet.com	Ashland*, Barron**, Bayfield*, Burnett**, Chippewa**, Clark**, Douglas*, Dunn**, Eau Claire**, Iron*, Pepin**, Pierce**, Polk**, Rusk**, Sawyer*, St. Croix**, Washburn*
Curative Contact: Deb Falk-Palec or Susan Bricco Phone: 414-479-9317 Email: vocserve@curative.org	Milwaukee, Ozaukee, Washington, Waukesha
ERI Contact: Ellyn Spence Phone: 608-246-3444 or 800-391-2950 Email: spence@eri-wi.org	Columbia, Dane, Dodge, Green, Jefferson, Kenosha, Racine, Rock, Walworth
Independence First Contact: Kathy Meisner-Altman Phone: 414-291-7520 Email: kmeisner-altman@independencefirst.org	Milwaukee, Ozaukee, Washington, Waukesha
Independent Living Resources Contact: Cheryl Ottens Phone: 888-474-5745 Email: Cheryl.ottens@ilresources.org	Buffalo, Crawford, Grant, Iowa, Jackson, Juneau, La Crosse, Lafayette, Monroe, Richland, Sauk, Trempealeau, Vernon

5.13 FAMILY CARE (FC)

5.13.1 DEFINITION

The Family Care (FC) program is a long-term care benefit and a new way of delivering long-term care services in selected pilot counties. The counties currently operating the Family Care program are Fond du Lac, La Crosse, Portage, Milwaukee and Richland.

Family Care target groups are elderly people, people with physical disabilities and those with developmental disabilities. Counties can choose to cover any or all of those target populations during the pilot phase of the program.

This page last updated in Release Number : 01-05
Release Date : 10-01-01
Effective Date : 10-01-01

5.13.2 ADMINISTRATION

Three groups work together to administer the Family Care program:

1. A **Resource Center** (RC) serves as a "one-stop" shopping point to provide information and assistance in accessing available support services, housing, costs, and community services. Resource Center staff also assess potential clients' functional level of care, which is an eligibility criteria.

2. **Economic Support Agencies** determine and certify Medicaid and Family Care non-financial and financial eligibility, and process Family Care enrollment.

3. **Care Management Organizations** (CMOs) complete a comprehensive assessment and develop a plan of care, as well as provide and/or coordinate long term services for Family Care enrollees. Participants in the Family Care program choose to be enrolled in a CMO.

This page last updated in Release Number : 01-05
Release Date : 10-01-01
Effective Date : 10-01-01

5.13.3 FAMILY CARE MA & NON-MA

There are two types of Family Care financial eligibility:

Family Care MA clients are eligible for MA services and receive a Forward Card.

They have their long-term care needs met via a Family Care CMO. They may have a cost share or a spenddown. In CARES, their MA eligibility is represented by an open MA assistance group (which may include a community waivers AG) for example NS, MCWW, MAOR, etc. Enrollment in the Family Care CMO is represented by an open "FC" assistance group in CARES. Family Care MA participants have both an open MA and an open FC AG.

Family Care Non-MA participants are not eligible for MA (usually due to excess assets or income). They do not receive a Forward Card. However they are eligible to receive their long-term care services via a Family Care CMO. They have a cost share. In CARES, Family Care non-MA participants will show a closed or denied MA AG, and an open FC AG which represents their enrollment in the Family Care CMO.

This page last updated in Release Number : 01-05
Release Date : 10-01-01
Effective Date : 10-01-01

5.13.4 Functional Eligibility

Resource Center staff use the Long Term Care Functional Screen to assess a Family Care applicant's long term care needs and to determine level of care. The functional level of care information is provided to the ES Worker so that s/he can determine eligibility for Family Care.

The levels of care are:

1. Comprehensive Nursing Home (CNH),
2. Comprehensive (COM),
3. Intermediate (ICF), and
4. Grandfather status for applicants who were receiving services from the county prior to the implementation of Family Care.

Use community waiver MA criteria to determine eligibility for clients with a Comprehensive Nursing Home (CNH) level of care. Determine eligibility for all other clients using EBD MA criteria.

This page last updated in Release Number : 01-05
Release Date : 10-01-01
Effective Date : 10-01-01

5.13.5 FAMILY CARE NON-MA ELIGIBILITY DETERMINATION

Use Family Care Non-MA eligibility criteria if the applicant has failed eligibility for all other categories of full benefit MA. This includes those with unmet deductibles.

5.13.5.1 Non-Financial Requirements

To be non-financially eligible, Family Care applicants must meet the EBD MA nonfinancial requirements with the following exceptions:

1. S/he must be 18 years of age or older.

2. S/he must be FC functionally eligible or meet the grandfather criteria.

3. The CMO network of providers must have the capacity to enroll the client and provide for his/her needs. The Resource Center worker gives this information to the ES worker.

4. S/he is not required to be determined disabled by the Disability Determination Bureau (DDB).

5. S/he must be a resident of the Family Care (FC) pilot county.

   Note: The client may be placed by the CMO outside of the county and maintain residency.

5.13.5.2 FC Non-MA Financial Eligibility Determination

Determination of FC Non-MA eligibility is a three-step process. The ES worker determines countable monthly asset and income amounts. The total of countable monthly assets and income is called the client's monthly resource amount. From this, calculate a monthly cost share.

There are no income or asset limits for Family Care Non-MA. An client is financially eligible if the monthly FC cost share is less than the projected monthly cost of the client's care plan at either the intermediate or comprehensive level. When determining initial eligibility, use a projected cost of care plan.

Use the Family Care Eligibility Non-MA Financial Determination worksheet (WKST 12) to determine eligibility.

5.13.5.2.1 FC Non-MA Net Countable Asset Determination

1. Determine the client's monthly net countable assets using EBD rules and MAHB sections 4.5.1 and 5.10.1. Count the assets of both the client and spouse if the client is legally married. If both spouses are applying, do calculations for each individually. Do not include Independence Accounts, or interest generated from these accounts.

2. From the total countable assets, deduct the following:

   a. The Community Spouse Asset Share (CSAS), if applicable (5.10.6).

If both spouses are being tested for FC/Non-MA, allow the CSAS for each spouse separately.

b. A Family Care basic asset allowance:

- If the client lives in a nursing home (NH), Community Based Residential Facility (CBRF), or Adult Family Home (AFH), disregard the Basic Asset Allowance (8.1.12.1).

- If the client lives in a private residence, a Residential Care Apartment Complex (RCAC) or other community setting, disregard the Basic Asset Allowance (8.1.12.1).

3. Divide the remainder by twelve. The result is the monthly net countable assets of the client.

5.13.5.2.2 FC Non-MA Income Determination

1. Determine the client's monthly earned income. Count any unemployment or worker's compensation payments as earned income for Family Care Non-MA.

2. Deduct $200 and 2/3 of the earned income from the client's monthly earnings. This is the adjusted earned income.

3. Determine unearned income using EBD rules (4.1.1).

4. Add the adjusted earned and unearned income together.

5. Deduct $20 from the combined income. The total is the client's countable monthly net income.

5.13.5.2.3 FC Non-MA Cost Share

1. Add the client's countable monthly net asset and countable monthly net income amounts. The total is the countable monthly resource amount.

2. From the total countable monthly resource amount, deduct the following, if applicable:

   a. Community Spouse income allocation amount (5.10.1).

   b. Court ordered payments (4.1.3.2.1).

   c. Basic needs allowance. The amount is based on the client's living arrangement:

- Basic needs allowance (8.1.12.1) if s/he lives in a Nursing Home, Adult Family Home or Community Based Residential Facility, or

- If the person lives in his/her own home or other community setting, the client receives the greater of the SSI Payment Level Plus the E Supplement (8.1.5) for one person or actual maintenance costs up to the EBD Maximum Personal Maintenance Allowance (8.1.5.1). Actual maintenance costs consist of shelter costs (rent, mortgage, taxes, insurance, condo fees, standard utility allowance, food stamp allotment for one person, and standard clothing allowance of $100 per month).

d. Home maintenance costs up to the SSI Payment Level Plus the E Supplement (8.1.5), if living in a medical institution but expected to return home within six months (4.1.3.1).

e. Out of pocket medical/remedial expenses (4.1.3.3).

f. Dependent family member income allocation amount (5.10.6).

g. Health insurance monthly premium amount (5.9.9.2.4).

The total countable monthly resource amount minus applicable deductions equals the monthly cost share amount.

To determine eligibility, compare the cost share amount to the cost of a Family Care projected plan of care for the functional level assigned to the client. The projected cost of care for clients is listed in 8.1.12.

If the cost share is less than the cost of the projected care plan, the client is eligible for Family Care Non-MA and must pay the determined cost share amount monthly.

If the cost share is greater than the projected plan of care, the client is not eligible for Family Care. However, the person may choose to purchase an assessment from the CMO to develop an actual care plan. If the cost of the actual care plan is greater than the person's cost share amount, the person is eligible for Family Care Non-MA. Use the actual care plan costs from the CMO in subsequent eligibility tests.

This page last updated in Release Number : 02-04
Release Date : 10-01-02
Effective Date :10-01-02

5.13.6 ENROLLMENT/DISENROLLMENT AND INTERCOUNTY MOVES

5.13.6.1 Enrollments

The enrollment date is always the date that the client is enrolled in the CMO. The Resource Center worker provides the ES worker with this information.

5.13.6.1.1 Urgent Services

Determine Family Care eligibility for a person who received urgent services as of the date the CMO began providing services. The CMO is paid the capitated rate as of that date, if the person is found eligible and chooses to enroll.

If the person is found ineligible for Family Care, the CMO bills the client for the care and urgent services it provided.

5.13.6.1.2 SSI Recipients

A full MA application or review is not necessary for an SSI recipient who asks to enroll in Family Care, and is not applying for Food Stamps. The RC worker will supply the ES worker with the following information:

1. Name.
2. Residence Address.
3. Mailing Address.
4. SSN (and MAID number if different).
5. Sex.
6. Primary Language (English or Spanish).
7. Guardian/Power of Attorney Name and Address.
8. Date of Birth.
9. Race (Optional)
10. Citizenship Status (Alien registration number, if not a citizen).
11. Disability Status (if not age 65 or older).
12. All information necessary to complete screens ANCW, AFME, ANMC and ANFR.

They may use the “Model Agency Referral Form” to provide this information. Workers can contact clients as needed for additional information.

5.13.6.2 Disenrollment

5.13.6.2.1 Adverse Action Disenrollment

CARES populates the date when there is ineligibility for FC. It is not worker enterable. The date will be an end of month date according to adverse action logic, except when the client dies. In this case, the disenrollment date is the date of death.

If a client asks to disenroll prior to the date set according to adverse action logic, fax the paper disenrollment form to the DHCF Enrollment Specialist at (608) 261-7793. The request will then be forwarded to EDS for entry in MMIS.

5.13.6.3 Inter-county Moves

When a FC enrollee moves permanently to a non-CMO county, s/he can remain enrolled in the CMO only if the Resource Center worker informs ES that the following four conditions are met:

1. S/he is eligible for COP or waiver services.

2. After moving to the new county, the enrollee resides in a long-term care facility (Nursing Home, CBRF, or AFH).

3. The enrollee's placement in the long-term care facility is done under and pursuant to a plan of care approved by the CMO.

4. The enrollee resided in the CMO county for at least six months prior to the date on which s/he moved to the non-CMO county.

This page last updated in Release Number : 02-04
Release Date : 10-01-02
Effective Date : 10-01-02

5.13.7 CLOSURES

If a FC case closes for any reason and re-opens without a new application, contact the CMO to determine if the client has been served continuously by the CMO. Note in case comments any information from the CMO.

If the client has been served continuously by the CMO, do not complete a new enrollment form. If a disenrollment date exists on ANFR, begin another segment with a start date for the day following the disenrollment date.

If the client has not been served continuously by the CMO, a new enrollment form signed by the client, and enrollment date are required.

This page last updated in Release Number : 02-04
Release Date : 10-01-02
Effective Date : 10-01-02

Medicare Buyins

5.14 MEDICARE BENEFICIARIES

5.14.1 INTRODUCTION

Medicare is the health insurance program administered by the federal Health Care Financing Administration for people over 65 and for certain younger disabled people.

Medicare is divided into two types of health coverage. Hospitalization Insurance (Part A) pays hospital bills and certain skilled nursing facility expenses. Medical Insurance (Part B) pays doctors' bills and certain other charges.

Medicare, being an insurance program, charges premiums. For the persons participating in the programs described below, Wisconsin Medicaid pays some or all of their Medicare premiums. This is called Medicare Buy-In. The persons who qualify for Medicare Buy-In are called Medicare Beneficiaries.

Use the same rules for determining financial eligibility as you do for Elderly, Blind, Disabled (EBD) MA.

5.14.1.1 Medicare Beneficiaries

1. Qualified Medicare Beneficiary (**QMB**).

2. Specified Low-Income Medicare Beneficiary (**SLMB**).

3. Specified Low-Income Medicare Beneficiary Plus (**SLMB+**), also known as Qualifying Individuals – 1 (**QI-1**).

4. Qualified Disabled and Working Individuals (**QDWI**).

If a client is also eligible for MA, they will receive a Forward card. The Forward card will indicate that they are Medicare Beneficiaries.

Clients eligible for QMB will receive a forward card even if s/he is not eligible for any other subprograms of MA.

This page last updated in Release Number : 03-02
Release Date : 04/01/03
Effective Date : 04/01/03

5.14.2 BENEFITS

1. **QMB**. MA pays Medicare Part A & B premiums and Medicare deductibles and co-payments.

2. **SLMB**. MA pays Medicare Part B premiums.

3. **SLMB** +. MA pays Medicare Part B premiums.

4. **QDWI**. MA pays Medicare Part A premiums.

This page last updated in Release Number : 03-02
Release Date : 04/01/03
Effective Date : 04/01/03

5.14.3 QMB

The following persons are MA recipients who are automatically eligible for QMB benefits.

1. Persons who are receiving or are eligible to receive SSI.

2. 503 AGs (5.11.1.1).

3. Disabled adult children (5.11.2).

4. Widows and Widowers (5.11.3).

Widow/widowers, DAC's and 503's have the option of not taking the QMB benefit. See 5.14.12.

If the person does not belong to one of the above named groups, s/he must:

1. Be non-financially eligible for Medicaid.

2. Be entitled to Medicare Part A.

5.14.3.1 Entitled to Medicare

A person is "entitled" to Medicare Part A if s/he meets one of the following conditions:

1. S/he does not have to pay Medicare Part A, and s/he is receiving Medicare Part A services as of the QMB determination.

Example 1: Mrs. Smith applies for QMB benefits August 15, 1989. She has a Medicare card with a Part A begin date of June 1, 1989. Since Medicare will pay for Part A services as of June 1, 1989, she is "entitled" to Part A at the time of the QMB determination.

2. S/he must pay a monthly premium to receive Medicare Part A, and s/he fits one of the following descriptions:

    a. S/he is a MA recipient and has been enrolled in Medicare sometime in the past. In this case the State will attempt to enroll him/her in Medicare Part A. QMB eligibility cannot begin prior to the Part A begin date.

Example 2: Mr. Helmuth's Part A lapsed because he did not work enough quarters for free enrollment and he could no longer afford the premiums. When he becomes eligible for MA, the State will begin paying his Medicare premiums.

    b. S/he is a MA recipient or QMB or SLMB or QDWI applicant and has never been enrolled in the federal Medicare system. In this case s/he must apply at the local SSA office for Part A Medicare eligibility. S/he will receive a receipt which entitles him/her to enrollment in Part A on the condition that s/he is found eligible for QMB or SLMB. The receipt from SSA will have a Part A begin date on it. QMB OR SLMB or QDWI eligibility cannot begin prior to the Part A begin date.

Example 3: Mrs. Brown was never enrolled in the federal Medicare system. She applies for QMB. Before she can become QMB eligible she must obtain a receipt for conditional eligibility for Part A Medicare. She goes to the SSA office during the January-March enrollment period and is conditionally determined eligible for Part A effective July 1st. She applies for QMB at the ESA on May 1st. She becomes QMB eligible as of July 1st.

5.14.3.2 QMB Income Limit

The QMB income limit is 100% of the federal poverty level (FPL). See 8.1.6.

The method of counting income is based on the SSI method, not on the spousal impoverishment (5.10) method. Calculate QMB net income as follows:

$ Earned income (4.1.5)
- $65 and ½ earned income deduction (4.1.3.6)
+ Unearned income (social security income, etc.) (4.1.4)
- Special exempt income (4.1.3.2)
<u>- $20 standard deduction</u>
= Net income used to determine QMB eligibility

When counting social security income, use gross social security income. Gross social security income:

1. Of a self-payer = the social security check amount + Medicare premiums

s/he has paid.

2. Of someone for whom the State is paying the premiums = the social security check amount.

Disregard the COLA increase for the current year until the month after the new federal poverty limits become effective.

Example: Big Al is a QMB recipient. He has income of $680. The QMB income limit in December is $686.67. In January, a COLA increase of $11.17 increases Big Al's income to $691.17. Disregard the COLA increase in any determination of Big Al's continuing QMB eligibility. On April 1st, new, higher QMB in-come limits are published. Redetermine Big Al's QMB eligibility in May. At this redetermination, do not disregard the January COLA increase.

This page last updated in Release Number : 03-02
Release Date : 04/01/03
Effective Date : 04/01/03

5.14.4 SLMB

To be eligible for SLMB the person must:

1. Meet non-financial EBD MA requirements.
2. Be receiving Medicare Part A.

5.14.4.1 SLMB Income Limit

The SLMB income limit is at least 100% of the FPL, but less than 120%. See 8.1.6.

Calculate SLMB net income in the same way as QMB net income (5.14.3.2).

This page last updated in Release Number : 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

5.14.5 SLMB+

To be eligible for SLMB+ the person must:

1. Meet non-financial EBD MA requirements.

2. Be receiving Medicare Part A.

3. Have been determined ineligible for MA (including Community Waivers, BadgerCare, QMB, SLMB, and QDWI). Consider a person with an unmet deductible ineligible for MA until s/he meets the deductible.

5.14.5.1 SLMB+ Income Limit

SLMB+ income must be at least 120% of the FPL, but less than 135%. See 8.1.6

Calculate SLMB+ net income in the same way as QMB net income (5.14.3.2).

This page last updated in Release Number : 03-02
Release Date : 04/01/03
Effective Date : 04/01/03

5.14.6 QDWI

A Qualified Disabled and Working Individual (QDWI) is a person who:

1. Is entitled (5.14.3.1) to enroll in Medicare Part A.

2. Is not otherwise eligible for MA (including Community Waivers and BadgerCare). Consider a person with an unmet deductible ineligible for MA until s/he meets the deductible.

5.14.6.1 QDWI Income Limit

The QDWI income limit is 200% of the FPL (8.1.6).

Calculate QDWI net income in the same way as QMB net income (5.14.3.2).

This page last updated in Release Number: 03-03
Release Date:09-22-03
Effective Date: 09-22-03

5.14.7 ASSET LIMIT

QMB, SLMB, SLMB+, and QDWI have the same asset limit. The asset limit is twice the EBD asset limit:

Group Size	Asset Limit
1	$4,000
2	$6,000

Divestment of assets has no effect on QMB, SLMB, SLMB+, or QDWI eligibility.

This page last updated in Release Number : 03-03
Release Date:09-22-03
Effective Date: 09-22-03

5.14.8 BEGIN DATE

5.14.8.1 QMB

QMB benefits begin on the first of the month after the month in which the individual is determined to be eligible/confirmed in CARES.

Example: Mr. Smith has been in the same nursing home since 1998 and applied for MA on January 23, 2003. He also requested QMB. His application was processed for both on January 23, 2003 and he was determined eligible for both. His MA begin date is January 1, 2003. His QMB begin date is February 1, 2003.

5.14.8.2 SLMB, SLMB+,QDWI

SLMB, SLMB+, and QDWI benefits begin on the first of the month in which all eligibility requirements are met. They cannot begin earlier than three months prior to the month of application.

This page last updated in Release Number : 03-03
Release Date:09-22-03
Effective Date: 09-22-03

5.14.9 BACKDATING

5.14.9.1 QMB

Occasionally, the benefits of a person who is eligible for QMB did not begin on the first of the following month as they were supposed to. This can occur if:

1. The eligibility process was not completed within 30 days.
2. Certification of eligibility was not completed.
3. A fair hearing decision has ordered backdated QMB benefits.

To backdate QMB benefit, complete an HCF 10110 (formerly DES 3070) certification form and return to:

1. Mail: EDS
   P.O. Box 7636
   Madison, WI 53707

2. E-mail: eds_3070@dhfs.state.wi.us

   Fax: (608) 221-8815

5.14.9.2 SLMB, SLMB+,QDWI

Benefits can be backdated for up to three months prior to the month of application. Use the backdating guidelines given in the Introduction to the MA Handbook, page 9.

A person who would have been eligible as a QMB in the backdate period cannot receive backdated SLMB, SLMB+, or QDWI benefits.

Example: Henry Schoolcraft applied for QMB on June 15, 1996. He also requested backdated SLMB. His income for June 1996 was under the QMB limit (100% of the federal poverty level). He was determined eligible for QMB. But his request for backdated SLMB was denied because his income, in the backdate months of March, April, and May, 1996, was under the QMB limit (100% of the FPL).

If he had applied for QMB in those months, he would have been QMB eligible. Therefore, since he would have been QMB eligible in the backdate period, he cannot receive backdated SLMB benefits.

This page last updated in Release Number : 03-02
Release Date : 04/01/03
Effective Date : 04/01/03

5.14.10 NO DEDUCTIBLE

There is no deductible (4.9) in the Medicare Beneficiary programs. If a person's income is above the appropriate income limit, s/he cannot become a Medicare Beneficiary by meeting a deductible.

Example: Mr. George’s net monthly income is too high for him to be eligible for any of the Medicare Beneficiary programs. He cannot become eligible through the MA deductible process. If he is also applying for MA medically needy eligibility, calculate his MA deductible (4.9.5). When he meets his MA deductible, he becomes eligible for MA, but not for any of the Medicare Beneficiary programs.

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

5.14.11 REVIEWS

Review Medicare Beneficiary only AGs every 12 months. If there are other persons in the AG who are not Medicare Beneficiaries, review whenever the case normally comes up for review.

This page last updated in Release Number : 03-02
Release Date : 04/01/03
Effective Date : 04/01/03

5.14.12 ADVERSELY AFFECTED

When the State pays a person's Part B premium, his/her Social Security (SS) check will increase by the same amount as the premium. This increase in the SS check may result in the person either losing MA eligibility, or being reduced from categorically needy to medically needy.

When a person would be adversely affected in this way, allow him/her to choose between either losing his/her MA current benefits and keeping free Medicare enrollment, or giving up the free Medicare enrollment and keeping his/her MA benefits. All but 503, DAC’s and widow/widowers can opt out of the QMB buy-in through CARES.

When a 503, DAC, or widow/widower requests to not have the state pay the Part B premium, contact the Buy-In Analyst at 221-4746, extension 3107. S/he will update MMIS with the appropriate information to prevent the automatic buy-in.

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

5.14.13 FISCAL TEST GROUP

The fiscal test group (FTG) size is two when a couple is living together at home. If they are both living in the same nursing home, each person is an individual FTG.

This page last updated in Release Number : 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

OTHER MA SUBPROGRAMS

5.15 FAMILY PLANNING WAIVER (FPW)

5.15.1 Definitions

5.15.1.1 Family Planning Waiver

The Family Planning Waiver (FPW) is a subprogram of the Wisconsin Medicaid (MA) program that provides limited benefits relating to family planning services for women who are:

1. 15 years of age or older and under age 45, **and**

2. Who have income at or below 185% of the Federal Poverty Level (FPL), **and**

3. Not receiving full-benefit MA (7.1.2)

Men are not eligible for this subprogram of Medicaid.

Women eligible for FPW may be eligible to receive more than one limited benefit MA subprogram, including:

1. Tuberculosis-related MA (5.11.7).

2. Qualified Medicare Beneficiary (5.14.3).

3. Specified Low-Income Medicare Beneficiary (5.14.4.).

4. Family Care Non-MA (5.13.3).

This page last updated in Release Number: 03-02
Release Date:04/01/03
Effective Date: 04/01/03

5.15.2 Presumptive Eligibility (PE)

FPW presumptive eligibility (PE) provides family planning services beginning on the day that a qualified provider determines that the woman is/has:

1. 15 years of age or older and under age 45, **and**
2. Wisconsin resident, **and**
3. A citizen of the U.S., **and**

   The qualified provider should refer non-citizens to the Economic Support

Agency (ESA) for a MA eligibility determination.

4. Income at or below 185% of the Federal Poverty Level (FPL),**and**
5. Not receiving a full-benefit MA subprogram (7.1.2)

FPW PE extends from the date that the woman is determined eligible by the qualified provider through two calendar months following the month of application. FPW PE can only be received once within a 12-month period.

Note: The FPW PE period extends one full calendar month longer than the PE period for pregnant women (5.2.4).

5.15.2.1 Qualified Providers

Qualified providers are certified by the Division of Health Care Financing (DHCF). A qualified provider will determine if a woman is presumptively eligible for the FPW. If she is found to be eligible, the qualified provider will:

1. Complete and sign the Medicaid Family Planning Waiver Presumptive Eligibility Application form (HCF 10119).

2. Fill out the temporary MA ID card at the bottom of the HCF 10119. The certification dates will be from the date FPW PE is determined through the end of the second month following the month in which the determination is made.

3. Give the woman the temporary MA ID card.

4. Explain that the duration of her FPW PE period depends on when she applies for MA and the ongoing FPW through her local ESA.

a. If she applies for ongoing FPW by the end of the second month following the month in which she became eligible for FPW PE, the ongoing FPW period begins the first of the month in which she applied and is found eligible. The FPW PE period ends the day before her ongoing FPW period is to begin.

Example 1: Amber applies for FPW PE on September 19th. Her FPW PE will continue through the end of November. Amber applies for ongoing FPW on November 2nd and is found eligible. Amber's ongoing FPW will begin November 1st, and her FPW PE will end October 31st.

b. If she does not apply by the end of the second month following the month in which she became eligible for FPW PE, the FPW PE period ends the last day of the second month following the month in which she was determined eligible for FPW PE.

Example 2: Brenda applied for FPW PE on April 3rd. Her FPW PE continued through the end of June. Amber does not apply for ongoing FPW until August 15th and is found eligible beginning August 1st. Brenda's FPW PE ended June 30th.

5. Send a copy of the completed HCF 10119 to the MA fiscal agent and the ESA within five days of completion.

5.15.2.2 At the ESA

If the woman applies for MA and/or ongoing FPW at the ESA on or before the last day of her FPW PE period:

1. Verify she is presumptively eligible by checking her temporary MA ID card or checking MMIS for a medical status code of "PF".

2. Assist her in filing the application. Consider the application filed if her name, address and signature are on the application.

3. If you are unable to finish processing her application by the end of her FPW PE period, submit a HCF 10110 (formerly DES 3070) to extend her FPW PE period for an additional calendar month.

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

5.15.3 Application

Eligibility for FPW goes back to the first of the month of application if all non-financial (5.15.4) and financial (5.15.6) eligibility requirements have been met. There is no three-month backdate period for FPW.

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

5.15.4 Non-Financial Requirements

The following are FPW specific non-financial requirements:

1. Be a woman 15 years of age or older and under age 45.

2. Not be receiving a full-benefit MA subprogram (7.1.2).

3. Meet all of the non-financial criteria listed in 1.1.2 with the two exceptions listed below:

a. Women applying for or receiving only the FPW do not need to cooperate with Medical Support Liability (MSL), unless she is also applying for or receiving MA (other than the FPW) for any child for whom she is the caretaker.

b. Women applying for or receiving only the FPW do not need to cooperate with Third Party Liability (TPL), unless she is also applying for or receiving Medicaid (other than the FPW) for any child for whom she is the caretaker.

Close any woman applying for or receiving the FPW who refuses to cooperate with MSL or TPL requirements when she has a child receiving Medicaid in the home, unless the woman is a minor or has good cause 3.3.5 and 6.3.3.3). A pregnant woman should not be denied the FPW if she refuses to cooperate with providing MSL information or TPL information if the source of the health insurance coverage is the absent parent of her child(ren).

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

5.15.5 Fiscal Test Group

The fiscal test group (FTG) includes:

1. The non-financially eligible household member, **and**
2. Her spouse, **and**
3. Her minor natural or adoptive children.

Example: Cheryl and Eric are not married, and have a child together, Alex. Cheryl is only requesting FPW for herself, and is requesting MA for Alex.

Alex is found eligible for Healthy Start. In building the FPW FTG, Alex is a counted child. Eric is not part of the FPW FTG, because he is only legally responsible for a counted child in the FPW FTG. The FPW FTG is a group size of two.

5.15.5.1 SSI Recipients

Do not include Supplemental Security Income (SSI) recipients in the FPW test or FTG. Do not count their income.

5.15.5.2 Fetus

Increase the FTG size by one for each fetus a pregnant woman in the FTG is carrying.

> **Example:** Samantha and Howard are married, and have two minor daughters, Shannon and Colleen. Shannon is pregnant. Samantha is only requesting FPW for herself, and is requesting MA for her two daughters.
>
> Shannon and Colleen are found eligible for Healthy Start. In building the FPW FTG, Shannon, Shannon's fetus, and Colleen are counted children. Howard is part of the FPW FTG, because he is legally responsible for Samantha. The FPW FTG is a group size of five for Samantha.

5.15.5.3 Minors

For minors that are applying for FPW, the FTG only includes the minor unless she is married and/or has children of her own. Do not include her parents in her FTG.

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

5.15.6 Financial

5.15.6.1 Assets

There is no asset test for FPW.

5.15.6.2 Income

Use the Family MA budgeting rules in 4.1, including prospective income budgeting (4.1.6). The following are specific FPW financial eligibility requirements:

1. The income that is reported in the application month is used to determine the client's financial eligibility for the entire 12-month eligibility period.

2. Any change in income or household size reported after confirmation for FPW during the 12-month eligibility period will only be applied to the client's FPW eligibility if it results in her becoming eligible for a full-benefit MA subprogram.

3. All changes in income or household composition that result in the woman

being found eligible for full-benefit MA will result in her FPW closing prior to the 12th month.

Example: Erin had applied for MA for her and her son Mike in January. Erin was found eligible for BC with a premium, and chose to receive FPW instead. May 6th she reports a decrease in income that results in her being found eligible for full-benefit MA without any cost sharing. Erin's full-benefit MA eligibility begins June 1st and her FPW ends May 31st.

4. All changes in income and household size will be applied at the 12-month FPW eligibility review.

Use the client's self-declared household gross income if she is only applying for a MA subprogram, including FPW. If the client is applying for any other program of assistance, use the appropriate prospective budgeting technique (4.1.6.1).

From the client's gross income subtract any of the following deductions that are applicable to determine the total family income:

1. $90 Earned Income Disregard (4.1.3.5).

2. Child Support Disregard (4.1.2.21).

3. Dependent Care (4.3.1.2).

4. Apply any other Family MA income disregards (4.1.2).

The total family income should then be compared against and should not exceed 185% of the FPL.

There is no deductible for a woman that exceeds the income limit.

5.15.6.2.1 Minors

Determine the income of minors applying by subtracting any applicable deductions from her gross income. Do not count the income of her parents in determining her eligibility.

Count any money that is provided to a minor by a member of her household, such as an allowance, as unearned income in the month received.

5.15.6.2.2 Migrants

See 5.11.8.2.

5.15.6.3 Family Fiscal Unit (FFU)

Apply Family Fiscal Unit (FFU) budgeting rules (4.8) when a woman fails FPW financial eligibility under Family MA FTG budgeting rules and one of the following applies:

1. The woman has minor children in the home.
2. The spouse has minor children in the home.
3. The woman is pregnant.

When testing a minor using FFU, do not include the minor's parents in the FFU size or allocate any income from the parents to the minor.

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

5.15.7 Program Choice

A woman applying for both MA and FPW will not be given a choice at the time of confirmation if she meets the eligibility requirement for another subprogram of MA in addition to FPW.

Confirm eligibility for any full-benefit MA subprogram, including BadgerCare (BC), that a woman requesting both MA and FPW is eligible for. All the eligibility requirements for that subprogram of MA apply, including restrictive reenrollment periods (5.7.9)., (5.12.6). A woman may request, at any time, that she does not want to receive full-benefit MA or BC in order to receive only FPW. Change the request switch on ACPA for MA or BC to "N" in order to receive the FPW.

A woman who is found to be eligible for a deductible may also be eligible for FPW benefits during the deductible period. She may receive FPW benefits until she has met her deductible. The client can report any out-of-pocket medical bills incurred while she is receiving services through FPW in order to meet her deductible. Once her deductible has been met, she is receiving full-benefit MA, so she is no longer eligible for FPW but will continue to receive the same services through full-benefit MA.

Example: Theresa is an 18-year-old woman applying for MA, BC, and FPW for her and her daughter Sara (age six). She is found to be eligible for BC with a premium or a deductible.

If Theresa chooses BC, she would need to pay a premium but would be able to receive family planning services through BC as well as having coverage for her whole family. If she chooses the deductible, she can receive family planning related services through FPW until her deductible has been met.

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

5.15.8 Changes

Women receiving FPW only are not required to report changes in income or household composition during the 12-month certification period. FPW recipients are still required to report all other changes within 10 days of the change.

Changes a woman reports in income or household composition that result in her income exceeding the FPW income limit will not affect her FPW benefits for the remainder of the 12-month certification period. The woman's eligibility will be put into an extension phase (5.15.9) until the end of the 12-month certification period or until she reports an income decrease that is again below the FPW income limit.

Changes a woman reports in income or household composition that result in her income decreasing to the point where she would be eligible for full-benefit MA, may be applied. If the woman has a request for full-benefit MA on file, she will be found eligible for full-benefit MA. At that time, her FPW will end.

FPW eligibility terminates when a woman loses non-financial eligibility. Terminate eligibility, using adverse action logic, if the client:

1. Reaches the age of 45 years.

2. Moves out of state.

3. Is an adult no longer cooperating with TPL, MSL, or Social Security Number (SSN) requirements.

4. Begins receiving full-benefit MA (7.1.2).

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

5.15.9 FPW Extension Phase

A woman will enter into a FPW extension phase if any of the following occur:

1. The woman reports a change at any other time during the 12-month certification period in income or household composition that results in income that exceeds the FPW income limit.

2. The woman's pregnancy extension (ME P or NE P) ended. If she has a request on ACPA for FPW and is not found eligible for full-benefit MA, she will be entered into a FPW extension phase. This would occur regardless of whether her income or household composition puts her income over the FPW income limit.

3. The woman did not report the end of her pregnancy timely, and therefore did not enter a pregnancy extension. If her Healthy Start (NHSP or MHSP) eligibility ended, and she was not found eligible for full-benefit MA. This would occur regardless of whether her income or household composition puts her income over the FPW income limit.

The extension phase will be indicated by an information reason code on CARES.

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

5.15.10 Reviews and Recertifications

Reviews/recertifications (2.2.2) are required every 12 months after the initial eligibility determination. At the time of the FPW review, the woman's income and household composition will again be tested against the FPW eligibility criteria. Like other MA subprograms, the client has the option of responding to the review process by mail, telephone, or in person.

If the woman completes a review for another program of assistance at any time during the 12 month certification period and the information collected from that review indicates that she still meets FPW eligibility requirements, her review date should be set 12 months from that review date.

If the woman completes a review for another program of assistance at any time before the 12th FPW income eligibility month, and is found to no longer meet the FPW eligibility requirements, she will be entered into a FPW extension phase (5.15.9). She will be required to complete a review at the end of the 12-month certification period. If at this review, she is found to still have income in excess of the FPW limit, her eligibility for the FPW extension ends.

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

5.15.11 Confidentiality

FPW clients have the same confidentiality protections as MA clients. In addition, women applying for or receiving FPW benefits will have the following additional confidentiality protections:

1. If requested, clients can have written communication sent to an alternate address instead of her home address.

2. Minors will not be referred to child support.

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

5.16 SENIORCARE (SC)

5.16.1 Introduction

Wisconsin SeniorCare (SC) is a prescription drug assistance program for Wisconsin residents who are at least 65 years of age and meet the program's eligibility criteria. SC began September 1, 2002.

SC is designed to help seniors with covered prescription drug costs. Eligible participants are issued SC identification cards and may receive SC benefits.

There is neither an asset test nor estate recovery for SC. Participation levels are determined by comparing the anticipated annual income of the fiscal test group (FTG) to a percentage of the Federal Poverty Level (FPL) corresponding to the FTG size.

SC is administered by the Department of Health and Family Services (DHFS), through the Central Application Processing Operation (CAPO). County and tribal agencies are not responsible for determining eligibility, but may need to coordinate with workers in the CAPO for mixed cases. Mixed cases include those persons eligible for SC and:

1. Food stamps, **or**
2. Medicare premium assistance, **or**
3. An unmet Medicaid (MA) deductible, **or**
4. Child care assistance, **or**
5. Are participating in a Department of Workforce Development (DWD) employment program such as Wisconsin Works (W-2).

Although SC is a subprogram of MA, only the portions of the handbook that are referenced in chapter 5.16 apply to SC policy.

This page last updated in Release Number: 04-02
Release Date: 04/30/04
Effective Date: 04/30/04

5.16.2 Application

An individual interested in participating in SC must complete a SeniorCare Application Form (HCF 10076). An application may be obtained from a local Office on Aging, Senior Center, or Aging Resource Center. Applications may also be printed from the Department of Health and Family Services web site at: http://www.dhfs.wisconsin.gov/seniorcare/index.htm. If the applicant is unsure where to obtain an application or wants to have one mailed to him/her, s/he should call 1-800- 657-2038 (TTY and translation services are available).

A $30 enrollment fee is required as a condition of eligibility. If the enrollment fee is not sent with the application, the eligibility begin date could be delayed (5.16.5.1).

SC applications should be mailed to:

SeniorCare
P.O. Box 6710
Madison, WI 53716-0710

NOTE: For benefit renewal requirements, see 5.16.15.

5.16.2.1 Application Processing

A valid application for SeniorCare is a SeniorCare Application Form (HCF 10076) with the applicant's:

1. Name, **and**
2. Address, **and**
3. Signature (5.16.2.2) in Section V. Applications that are not signed in Section V of HCF 10076 will be returned to the applicant. (Section VI of the 07/02 version of HCF 10076)

However, non-financial (5.16.3) and income (5.16.6) information is needed to determine eligibility.

"General Delivery" may be used for a mailing address but can not be used as a residence address.

The presence of a signature on a SC application indicates intent to apply. When a signed application is received without an enrollment fee, the department will send an enrollment fee request notice to the applicant(s). An application will not be approved until an enrollment fee is received.

When an application is received with an enrollment fee(s) where the applicant(s) has answered "No" to the question "Are you Requesting SeniorCare?", the department will assume that there is a request for at least one person. When an application is received without the enrollment fee where the applicant's answer to the question is "No", the department will follow up with the applicant(s) to determine his/her intent.

The date a valid application is received by the SC program is the application filing date. Eligibility for SC will be determined as soon as possible, but not later than 30 days from the date a valid application is received.

A delay in processing the application may occur if there is a delay in obtaining information or in receipt of the enrollment fee necessary for determining eligibility. If a delay occurs, the applicant will be notified in writing that there is a delay in processing the application. The notice will specify the reason for the delay and inform the applicant of his/her right to appeal the delay.

If the initial application is denied and the applicant wishes to reapply, s/he should check the “New Application” box on the application form. “Reapplication” refers to current participants who are requesting establishment of a new benefit period due to a change in circumstances.

5.16.2.2 Signing the Application

The applicant must sign the application form in Section V of HCF 10076 (Section VI of the 07/02 version of HCF 10076) with his/her signature, a mark or an “X”, unless one of the following signs for him/her:

1. A guardian.

2. An authorized representative.

3. A power of attorney/durable power of attorney. (Health Care Power of Attorney is not accepted as proof of authority.)

5.16.2.2.1 Witnessing the Signature

If a SC applicant signs the application form in Section V of HCF 10076 with a mark or an “X”, the signature must be witnessed by two individuals. (Section VI of the 07/02 version of HCF 10076)

5.16.2.3 Authorized Representative

An authorized representative may act on behalf of the SC participant at application and/or reviews, and is authorized to provide information and any documentation that is necessary to establish SC eligibility.

A SC applicant may authorize someone to represent him/her by completing the authorized representative form HCF 10080. (Note: The early version of SC application included Section V for authorizing a representative. If the 07/02 version of HCF 10076 is submitted with Section V completed, SC will accept the authorization of the representative.)

5.16.2.4 Guardian and Power of Attorney

An applicant is not required to complete the Authorized Representative form HCF 10080 if a legal guardian or power of attorney (POA) is applying on the SC applicant’s behalf.

Copies of guardianship or POA documentation will be requested after the SC application has been submitted. Documentation must be submitted to the SC Program before information about the applicant or participant will be released to the guardian or POA. A POA may also be authorized for representation by completing the authorization of representation form (HCF 10080) SeniorCare Authorization of Information in lieu of submitting the POA papers.

This page last updated in Release Number: 04-02
Release Date: 04/30/04
Effective Date: 04/30/04

5.16.3 Non-Financial Requirements

To be non-financially eligible for SC, an applicant must:

1. Be at least 65 years of age.
2. Be a Wisconsin resident.

A Wisconsin resident is an individual who meets at least one of the following criteria:

1. Has a permanent residence in Wisconsin.
2. Is considered a Wisconsin resident for tax purposes.
3. Is a registered voter in Wisconsin.

   A SC participant may temporarily live outside the State of Wisconsin, as long as s/he maintains permanent residency in Wisconsin. Residency in a Wisconsin nursing home or an assisted living facility will meet this requirement.

4. Be a U.S. citizen or a qualifying legal alien (3.2.2).

   An applicant who is a resident alien will need to provide a copy of both sides of his/her alien card and identify his/her country of origin. If there are discrepancies between reported and verified data, supporting legal documentation must be provided by the applicant. When legal documentation is not available and SSA benefits have been verified, this requirement has been met.

   Verification of alien status can be made through the U.S. Bureau of Citizenship and Immigration Services' Systematic Alien Verification for Entitlement (SAVE) program.

5. Provide a Social Security Number (SSN) or be willing to apply for one (1.2.3.1).

Applications without the SSN will not be returned. Applicants will be contacted and given an opportunity to provide a SSN. Eligibility will not be confirmed until the SSN or proof of application for SSN has been supplied. If the SSN or the proof of application is not received within 30 days of application for SC, eligibility will be denied and any enrollment fee received will be refunded. The individual can reapply once they have their SSN. The Eligibility begin date will be based on the new application receipt date.

If a person requires assistance in obtaining a SSN, the SC Program will assist him/her in applying for one.

6. Not be a full-benefit MA recipient (7.1.2). This includes participants who are covered by Family Care MA. (5.13.3)

   Individuals are not considered MA recipients for SC if they have an unmet MA deductible (4.9) or receive one of the following:

   a. Medicare premium assistance (5.14).
   b. Family Care non-MA (5.13).
   c. TB-related MA (5.11.7)
   d. Emergency Services (3.2.3).

7. Not be an inmate of a public institution (1.1.2, #4).

8. Cooperate with providing information and/or verification   necessary to determine eligibility (1.2.2) and for quality assurance purposes.

   If a person requires assistance in obtaining the required verification, the SC program will assist him/her.

   If a person is not able to produce the required verification, and the SC program is not able to produce the required verification, the SC program may not deny assistance.

   If a person is able to produce required verification but refuses or fails to do so, the application will be denied.

5.16.3.1 Enrollment Fee

In addition to the non-financial requirements listed above, each applicant must pay a $30 annual enrollment fee. The enrollment fee must be paid prior to eligibility confirmation. When a participant reapplies for a new benefit period, a new enrollment fee is required.

When a SC enrollment fee check is returned for non-sufficient funds, the applicant is mailed a form letter and provided ten calendar days to submit a replacement check. If a replacement check is not received, a form letter giving another 10 days to replace the fee is sent to the participant. If the check is still not replaced, then the eligibility is terminated. A notice of decision is mailed to the participant. The termination date is 10 days after the notice of the decision (mail) date.

5.16.3.1.1 Refunds

No Application Received

If CAPO receives a fee without an application a manual notice and application will be sent, if possible, to the individual from whom the fee was received. If an Application is not received by CAPO within 45 days of the receipt of the fee, a refund will be processed at the request of the person who submitted the fee.

Application Denied

Anytime an application for SC is denied, a refund of the paid enrollment fee is automatically issued. A refund may be requested prior to eligibility being confirmed or within specified timelines outlined below.

Opt out

Refunds are based on individual participation. A SC participant may receive an enrollment fee refund if s/he received an initial eligibility notification, but has not received any SC prescription drug benefits or services and requests to withdraw from the program (5.16.12.1).

In all opt-out cases, a refund will be issued only if the request to withdraw from the SC program is received by the later of:

1. Ten days following issuance of the eligibility notice, **or**
2. 30 days from the application filing date.

The date by which a request for refund must be received will be printed on the initial eligibility determination notice. Filing of a hearing request will not delay these deadlines for refunds.

5.16.3.1.2 Refunds to Deceased Participants

A refund may also be requested by the family member of a deceased participant when all the following criteria are met:

1. S/he received an eligibility notification, **and**
2. Death occurs prior to the start of or within 30 days of the beginning of the SC benefit period, **and**
3. The request is made within 10 days of the date of death; **and**
4. S/he had not received any SC prescription drug benefits or services.

NOTE: If all of the above conditions are met, a refund will be issued even if the death is reported beyond the refund deadline date.

5.16.3.1.3 Opt In

Once the opt-out of eligibility is confirmed, the participant will have 30-days to contact the CAPO if s/he chooses to “opt in” to the program. S/he would need to send another enrollment fee if the original enrollment fee has been refunded. A new application is not required to opt in.

A participant who decides after the 30-day period that s/he wants to rejoin the program will need to complete a new application and submit the enrollment fee.

5.16.3.2 Age Limitation

A single applicant should apply for SC no sooner than 30 days before his/her 65th birthday.

When a couple applies where one spouse is 65 or older and the other is under 65 at the time of application, only the spouse that is 65 or older can be determined eligible. If both apply, the younger spouse would be denied SC unless s/he is turning 65 within 30 days. If the younger spouse will turn 65 within the 12-month enrollment period, s/he will receive a notice pending his/her eligibility for the enrollment fee approximately one month prior to his/her 65th birthday.

5.16.3.3 Other Insurance

Applicants who have prescription drug coverage under other health insurance plans, including Medicare Parts A and B, may enroll in SC. SC is the payor of last resort except state funded only programs such as Wisconsin Chronic Disease Program (WCDP) and HIRSP.

SC will coordinate benefit coverage with all other health insurance coverage. SC may also coordinate benefits with pharmacies that accept discount cards. Questions about individual health insurance coverage should be directed to the health insurance company. Questions regarding insurance carriers should be directed to:

Office of Commissioner of Insurance
Bureau of Market Regulation
PO Box 7873
Madison, WI 53707-7873
1-800-236-8517

5.16.4 Fiscal Test Group (FTG)

The FTG consists solely of an applicant, unless the applicant is married and resides with his/her spouse.

If the applicant is married and resides with his/her spouse, the FTG consists of both the applicant and his/her spouse. An applicant is considered to be residing with his/her spouse if the permanent residence of the spouse is the same as that of the applicant.

Exceptions: The FTG consists only of the applicant if:

1. One spouse is institutionalized and is expected to be out of the home for 30 or more days, **or**
2. The applicant's spouse is a SSI recipient, **or**
3. The applicants are married but are living separately, **or**
4. Both spouses are living in a nursing home.

This page last updated in Release Number: 04-02
Release Date: 04/30/04
Effective Date: 04/30/04

5.16.5 Benefit Period

The benefit period for SC is 12 consecutive months. The benefit period and eligibility remain intact unless the participant :

1. Moves out of state,
2. Reapplies (5.16.11),
3. Requests to withdraw from the program (5.16.12.1), or
4. Dies.

5.16.5.1 ID Cards

When an applicant is found eligible for SC, s/he is mailed a plastic SeniorCare ID card and information about how to use it. SC participants who renew their eligibility will continue to use their original card.

5.16.5.2 Eligibility Begin Date

SC begins on the first day of the month following the month in which all eligibility requirements have been met.

Exception: SC eligibility begins the day after MA eligibility ends if a SC application is submitted prior to the MA termination date and all eligibility requirements are met.

Example 1: Carol applies for SC on September 19th and meets all eligibility requirements. Her application is processed on October 10th, and eligibility is confirmed the same day. Carol's benefit period is from October 1st through September 30th.

Example 2: William applied for SC on September 19th but did not submit the enrollment fee with his application. His eligibility "pends" and a notice is issued. William submits the fee on October 1st and eligibility is confirmed the same day. William's benefit period is from November 1st through October 31st.

Example 3: Mary is notified that MA eligibility will end on November 30th because her assets exceed the limit. She applied for SC on November 29th and will meet all SC eligibility requirements on December 1st (when she is no longer an MA recipient). Mary's benefit period is from December 1st through November 30th.

This page last updated in Release Number: 04-02
Release Date: 04/30/04
Effective Date: 04/30/04

5.16.6 Financial Requirements

Income information for SC is based on the applicant's good faith estimate of income for the next 12 months beginning with the month of application. Last year's information from tax returns or other sources may be used as a guide when determining the estimate.

All income should be rounded to the nearest whole dollar when entering the amount on the application or renewal application.

5.16.6.1 Assets

There is no asset test for SC. In general, cash that is received as a result of converting an asset from one form to another, is not income. This includes withdrawals from savings and/or checking accounts, certificates of deposit, or money market accounts. However, special provisions apply to retirement benefits (5.16.6.7.1). Income generated from any assets that the SC participant may have is considered budgetable income and must be reported on the application or renewal application.

Example: Eric has a savings account with $5,000 in it. Eric's savings account is considered an asset, but the interest that he anticipates earning is countable income.

Eric anticipates withdrawing $1,000 from his savings account during the coming year. This amount does not count as income. It is an asset that has been converted to cash. Only the interest Eric anticipates receiving from the savings account is countable income. Any withdrawals from his savings account are considered the conversion of an asset, and are not counted as income.

5.16.6.2 Income

The income of a spouse who is in the SC FTG is included in the estimate of the annual budgetable income, even if s/he does not apply or is non-financially ineligible.

Annual income is determined prospectively from the month of application through the next 12 calendar months. Income exempted for MA eligibility is also exempted for SC (4.1.2), including Earned Income Tax Credit (EITC) and income tax refunds (4.1.5.8).

Budgetable income consists of projected gross annual income, except for self-employment income, which uses net income. (5.16.6.6).

In the following income related sections, policy is defined according to the categories on the SeniorCare Application Form (HCF 10076). All income listed in the following sections should be prospectively budgeted for a 12-month period beginning with the month of application.

5.16.6.3 Gross Social Security

When reporting anticipated gross annual Social Security income, include any deductions for Medicare Part B and court ordered guardianship fees, alimony and/or child support.

Exception: If a SC applicant is receiving Medicare premium assistance (5.14), his/her monthly payment already includes the Medicare Part B premium.

The applicant should contact the Social Security Administration at 1-800-772-1213 if s/he does not know his/her Medicare premium amount.

When the applicant is a surviving spouse receiving benefits under his/her spouse's Social Security number, the amount should be considered the applicant's income and reported under the applicant's income column of the application.

5.16.6.4 Gross Earnings

Budgetable gross earnings consist of all gross earned income, except for self-employment income, which uses net income (5.16.6.6). Gross earnings include the following:

1. AmeriCorp (4.1.5.10),
2. Contractual Income (4.1.5.2),
3. Governor's Central City Initiative (4.1.5.7),
4. Income In Kind (4.1.5.1),
5. Income Received By Members of a Religious Order (4.1.4.16, 4.1.5.13),
6. Jury Duty Payments (4.1.5.4),
7. Salary,
8. Severance Pay (4.1.5.12),
9. Wage Advances (4.1.5.5),
10. Wages,
11. Wages and salaries received from a program funded under Title V – Older Americans Act of 1965 (4.1.5.14),
12. Worker's Compensation (4.1.5.6),
13. Respite Care Payment for Services

5.16.6.5 Interest and Dividends

The SC applicant must report the estimated gross amount of all interest and dividends that s/he expects to receive in the next 12 months, beginning with the month of application. Sources of interest and dividends include, but are not limited to the following:

1. Bonds,
2. Certificates of Deposit (CD),
3. Checking Accounts,
4. Money Market Accounts,
5. Savings Accounts
6. Stocks,
7. Capital Gains (5.16.6.5.1)
8. Trusts (5.16.6.5.2)
9. Individual Retirement Accounts (4.1.4.4)
10. Annuities
11. Land Contracts (4.1.4.7)
12. Loans (4.1.4.8)

Payments do not need to be directly received. If they are rolled back into the asset, they still must be reported.

Irrevocable interest that a SC applicant receives for an irrevocable burial trust is not budgetable income.

Note: Unlike MA, income that is received irregularly infrequently, and under $20 per month **should** be reported as budgetable income for SC applicants.

5.16.6.5.1 Capital Gains

Budgetable income consists of all anticipated capital gains that would be reportable as capital gains to the IRS for tax purposes. All anticipated losses should be subtracted from the gross capital gains amount, and the net capital gain amount should be reported if it is greater than zero. Negative amounts should not be reported and shall not be used to offset other types of income.

The principal or initial investment in the capital asset that the person receives in cash when s/he sells the asset is not considered income. That portion is considered a conversion of an asset from one form to another.

5.16.6.5.2 Trusts

All anticipated payments (including interest, dividends, rent, and withdrawals from principal) from a trust to the applicant are counted as income.

Irrevocable interest that a SC applicant receives for an irrevocable burial trust is not budgetable income.

Note: Unlike MA, withdrawals from principle **are** counted for SC as income in the month received.

5.16.6.5.3 Joint Savings

Each person who is a holder in a joint savings account is assigned an equal share of the interest earned. The applicant/applicant's spouse should report only his/her share of the interest.

If the applicant and his/her spouse are not living together and hold a joint savings account, the applicant should only report his/her share of the interest

5.16.6.6 Self-Employment Earnings

SC will budget net self-employment income, which is calculated by deducting estimated business expenses, losses, and depreciation from gross self-employment income.

If the net self-employment earnings are anticipated to be a loss, the amount should be reported as zero.

Negative amounts should not be reported and shall not be used to offset other income. (4.2.5.2)

5.16.6.6.1 Rental Income

If rental income is reported to the IRS as self-employment income and is subject to the federal self-employment tax for rental income (usually real estate agents or individuals in a business where extensive services are provided to the renters), depreciation should also be deducted from the gross rental income.

Refer to 5.16.6.8.3 if rental income is not reported as self-employment income.

Note: See section 4.1.5.3, items #1 and 2, for more information about calculating net rental income for SC participants.

5.16.6.7 Gross Pension

Examples of income that should be included in the gross pension amount include:

1. Railroad Retirement Benefits,
2. Retirement Benefits (5.16.6.7.1),
3. Veteran's Benefits. (4.1.2.27)

5.16.6.7.1 Retirement Benefits

Retirement benefits are work-related plans for providing income when employment ends (e.g., pension, disability, or retirement plans administered by an employer or union). Other examples are funds held in an individual retirement account (IRA) and plans for self-employed individuals, sometimes referred to as Keogh plans.

Retirement accounts, including individual retirement accounts (IRA), Keogh, etc., are assets, and are therefore not counted for SC.

Periodic payments received from a retirement account or annuity are counted as income. A periodic payment is any partial payment from a retirement account. Withdrawal of the full amount from any retirement account that has never had a withdrawal made from it is not considered a periodic payment and is not countable income.

Note: Rolling over an IRA (transferring the funds from one IRA to another) is the conversion of an asset from one form to another. Any potential income from an IRA rollover is countable income for SC.

Example: Mike owns a $2000 IRA and plans to withdraw all of it this year. Mike has not withdrawn any money from this IRA in the past.

If Mike withdraws the full $2,000 at one time, the $2,000 continues to be considered an asset. This is a conversion from one form of an asset to another.

If Mike were planning to make a one time withdrawal of $1,000 of the $2,000 from his IRA in the next 12 months, the $1,000 would be considered income on his SeniorCare application.

If Mike were planning to withdraw $100 monthly from his IRA in the next 12 months, the $100 he plans to receive monthly from the IRA is counted as income on his SeniorCare application.

5.16.6.8 Other Income

Examples of other income are:

1. Allocated income from a MA recipient spouse (5.16.6.8.1),
2. Child Support (4.1.4.14),
3. Federal Farm Subsidy (5.16.6.8.2),
4. Gifts (4.1.4.6),
5. Profit sharing (4.1.4.15),
6. Sick/Disability benefits (4.1.4.2),
7. Rental income (5.16.6.8.3),
8. Unemployment Compensation (4.1.4.3),
9. Veteran's Disability Payments (5.16.6.8.4)

5.16.6.8.1 Allocated Income from a MA Recipient's Spouse

SC applicants with an MA recipient spouse living outside of the home (e.g. in a nursing home) must report the spousal income allocation amount (5.10.6) as income.

Example: Betty is an MA recipient and in the nursing home. She is allowed to allocate up to $1,000 to her spouse, Carl, according to the notice she receives. Betty only actually has $650 available, and of that $45 is set aside as her personal needs allowance. $605 per month that she allocates to Carl would be counted as unearned income for Carl. He would report $7,260 as "Other Income" on his SeniorCare Application.

A SC applicant with an MA recipient spouse living in the home (e.g. a community waivers participant) should not report income that is allocated to him/her. The allocated amount must be included in the income estimate for the MA recipient spouse, because s/he is living in the home.

5.16.6.8.2 Farm Subsidy

The SC applicant must report anticipated farm subsidy payments. The SC applicant must also report payments from the Conservation Reserve Enhancement Program (CREP), a program where the landowner is paid to install conservation practices for a period of 10 to 15 years.

5.16.6.8.3 Rental Income

All expected rental income will be budgeted for SC. Annual operating expenses should be deducted from the annual amount of gross rental income. Operating expenses include ordinary and necessary expenses such as insurance, utilities, taxes, advertising for tenants, and repairs. Repairs include expenses such as repainting, fixing gutters or floors, plastering and replacing broken windows.

Refer to 5.16.6.6.1 if rental income is reported to the IRS as self-employment income.

5.16.6.8.4 Veterans' Disability

Veterans' disability payments should be reported as income.

Do not count as income the portion of a veterans disability payment that is for: unusual medical expenses, aid and attendance, or a housebound allowance.

The applicant should check with the Veterans Administration at 1-800-827-1000 to determine if any portion of the payment is considered an allowance for unusual medical expenses, aid and attendance or housebound allowance.

Reimbursement from the Veterans Administration for medical costs does not count as income.

5.16.6.9 Disregarded Income

The applicant should not report income anticipated from any of the following:

1. Active Corp. of Executives (ACE) (4.1.2.2)
2. Adoption assistance payments (4.1.2.19)
3. Agent Orange Settlement Fund payments (4.1.2.10)
4. Disaster and emergency assistance payments made by federal, state, county and local agencies or other disaster assistance agencies (4.1.2.4)
5. Earned Income Tax Credit (4.5.7.8)
6. Earnings of a census enumerator (4.1.2.2)
7. Emergency Fuel Assistance payments (4.1.2.2)
8. Foster Care payments (4.1.2.18)
9. Foster Grandparents Program (4.1.2.2)
10. Governmental rent or housing subsidies (4.1.2.2)
11. Homestead Tax Credit (4.1.2.2)
12. Income Tax Refunds (both state and federal) (4.5.7.7)
13. Individual Development Account payments (4.1.2.5)
14. Kinship Care payments (4.1.2.24)
15. Low-Income Energy Assistance Program (4.1.2.2)
16. Older American Community Service Program (except for wages or salaries which are counted) (4.1.2.2)
17. Payments made to individuals because of their status as victims of Nazi persecution (4.1.2.12)
18. Payments received from the class action settlement of Susan Walker vs. Bayer Corporation. These payments are to hemophiliacs who contracted the HIV virus from contaminated blood products (4.1.2.22)
19. Penalty payments made when the state does not correctly process child support refunds.
20. Radiation Exposure Act program payments made to compensate injury or death due to radiation from nuclear testing and uranium mining (4.1.2.11).

21. Reimbursement from private insurance company for medical, long-term care, or dependent care expenses (4.1.2.8).
22. Restitution payments to individual Japanese-Americans (or 5.16.6.9 their survivors) and Aleuts who were interned or relocated during WWII (4.1.2.20).
23. Retired Senior Volunteer Program (RSVP) (4.1.2.2)
24. Reverse mortgage payments (4.5.7.2.1)
25. Service Corp. of Retired Executives (SCORE) (4.1.2.2)
26. University Year for Action Program (4.1.2.2)
27. Volunteers in Service to America (VISTA) (4.1.2.2)
28. W-2 payments for transitional jobs and community service jobs (4.1.2.25)
29. Wisconsin's Family Support Program (4.1.2.2)
30. Do not count payments from Indian Health Services. **Note: Payments to Native Americans listed in 4.1.2.1 must be counted.**

This page last updated in Release Number: 04-02
Release Date: 04/30/04
Effective Date: 04/30/04

5.16.7 Participation Levels

For applicants determined eligible, SC pays for a portion of covered prescription drugs (5.16.16), depending on the person's participation level.

Effective with benefit periods starting September 1, 2003 there are four participation levels. The level of benefits an applicant receives depends on his/her annual income and, for some, on the amount they spend on covered prescription drugs during their 12-month benefit period.

The participation levels are:

1. **Level 1: Co-Payment**
   (Annual income is at or below 160% of the FPL.)
2. **Level 2a: Deductible $500**
   (Annual income is greater than 160% of the FPL and less than or equal to 200% of the FPL.)
3. **Level 2b: Deductible $850**
   (Annual income is greater than 200% of the FPL and less than or equal to 240% of the FPL.)
4. **Level 3: Spenddown**
   (Annual income is above 240% of the FPL.)

Note: The FPL is set annually by the Department of Health and Human Services see 8.1.14

If the FPL changes during the eligibility determination process or before a redetermination can be completed, the new levels will be used.

SeniorCare Levels of Participation	
Income Limits*	**Annual Out-of-Pocket Expense Requirements and Benefits**
Level 1 **Income at or below 160% of FPL** At or below $14,896 per individual or $19,984 per couple annually.*	No deductible or spenddown. $5 co-pay for each covered generic prescription drug. $15 co-pay for each covered brand name prescription drug.
Level 2a **Income above 160% and at to or below 200% FPL** $14, 897 to $18,620 per individual and $19,984 to $24,980 per couple annually.*	$500 deductible per person. Pay the SeniorCare rate for drugs until the $500 deductible is met. After $500 deductible is met, pay a $5 co-pay for each covered generic prescription drug and a $15 co-pay for each covered brand name prescription drug.
Level 2b **Income above 200% - and at or below 240% of FPL** $18,621 to $22,344 per individual and $24,981 to $29,976 per couple annually.	$850 deductible per person. Pay the SeniorCare rate for most covered drugs until the $850 deductible is met. After $850 deductible is met, pay a $5 co-pay for each covered generic prescription drug and a $15 co-pay for each covered brand name prescription drug.
Level 3 **Annual income is above 240% of the FPL** $22,345 or higher per individual and $29,977 or higher per couple annually.*	Pay retail price for drugs equal to the difference between your income and $22,345 per individual or $29,977 per couple. This is called "spenddown." Covered drug costs for spenddown will be tracked automatically. During the spenddown, there is no discount on drug costs. After spenddown is met, meet an $850 deductible per person. Pay SeniorCare rate for most covered drugs until the $850 deductible is met. After the $850 deductible is met, pay a $5 co-pay for each covered generic prescription drug and a $15 co-pay for each covered brand name prescription drug.

* These income amounts are based on the 2004 federal poverty guidelines,

which increase by a small amount each year.

5.16.7.1. Level 1 : Co-Payment

SC will pay for covered prescription drugs purchased from participating pharmacies except for participant co-payments.

Level 1 participants are required to pay a $5 co-payment for each covered generic prescription drug, and a $15 co-payment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the $15 brand name co-pay.

If a participant has private insurance with a higher co-payment per prescription than SC, the SC co-payment rules will apply and benefits will be coordinated with the private insurance company. Providers who have questions regarding billing/benefit coordination should contact Provider Services Hotline at 1-800-947-9627.

Residents of nursing homes and community based residential facilities will have to pay the usual SC co-payment even when they are required to purchase drugs on less than a monthly basis.

5.16.7.2 Level 2a: Deductible

Participant has an annual deductible of $500. Participant will get a discount off the retail price for most covered prescription drugs during the deductible period. The discount amount depends on the particular drug prescribed.

After this deductible is met, a level 2a participant is required to pay a $5 co-payment for each covered generic prescription drug, and a $15 co-payment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the $15 brand name co-pay.

5.16.7.2.1 Level 2b: Deductible

Participant has an annual deductible of $850. Participant will get a discount off the retail price for most covered prescription drugs during the deductible period. The discount amount depends on the particular drug prescribed.

After this deductible is met, a level 2b participant is required to pay a $5 co-payment for each covered generic prescription drug, and a $15 co-payment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the $15 brand name co-pay.

Note: If married persons in the same FTG with annual income above 160% of

FPL are determined non-financially eligible at different times, the deductible amount is prorated for the spouse who applies later. (5.16.9.2.1)

5.16.7.3. Level 3: Spenddown

Level 3 participants must meet a spenddown. The amount of spenddown is the difference between the FTG annual income and 240% of the FPL corresponding the size of the FTG. The SC program tracks the amount spent on covered prescriptions drugs that can be applied to an applicant's spenddown.

5.16.7.3.1 Level 3: FTG of One

A SC participant considered as a FTG of one with gross annual income above 240% FPL pays retail prices for covered prescription drugs until those payments equal the spenddown amount.

After the spenddown has been met by purchasing drugs at regular prices the participant has an annual deductible of $850. During the deductible period the participant will get a discount off the retail price for most covered prescription drugs during the deductible period.

After this deductible is met, s/he is required to pay a $5 co-payment for each covered generic prescription drug, and a $15 co-payment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the $15 brand name co-pay.

Example: Dorothy's annual income is $23,344. This is $1,000 more than 240% of the FPL for a FTG of one (8.1.14). Her spenddown amount for the 12-month benefit period is $1,000. Dorothy pays the retail price for her covered prescription drugs until those payments equal the spenddown amount.

If Dorothy meets the spenddown during her benefit period, she can begin purchasing covered prescription drugs at the discounted rate. These costs are applied toward the $850 deductible.

After this deductible is met, Dorothy purchases covered prescription drugs at the co-payment amounts for the remainder of her benefit period

5.16.7.3.2 Level 3: FTG of Two

Married persons considered as a FTG of two with annual income greater than 240% FPL and in which both spouses are determined non-financially eligible at the same time pay retail price for covered prescription drugs until the spenddown requirement is met. In this case, the spenddown amount is shared, and covered prescription drugs purchased for either person in the married couple will count toward meeting the spenddown requirement, when both are eligible.

After the spenddown has been met, each spouse must meet a separate $850 deductible requirement. Participants will get a discount off the retail price for most covered prescription drugs during the deductible period. Only the covered prescription drugs purchased for an individual spouse may count toward that spouse's deductible.

After a spouse has met his/her deductible, s/he is required to pay a $5 co-payment for each covered generic prescription drug, and a $15 co-payment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the $15 brand name co-pay.

Example 1: Bob and Alice's annual income is $31,976, which is $2,000 more than 240% of the FPL for a FTG of two (5.16.7). Both spouses are eligible and, for the 12-month benefit period, their joint spenddown amount is $2,000.

Bob and Alice pay for their covered prescription drugs at retail price until the $2,000 spenddown is met. Covered prescription drugs purchased for either Bob or Alice will count toward the spenddown requirement.

After Bob and Alice meet the spenddown, each person has a $850 deductible. Only covered prescription drugs purchased for Bob count toward his deductible, and only covered prescription drugs purchased for Alice count toward her deductible.

Bob meets his deductible in two months. He then purchases covered prescription drugs at the co-payment amounts for the remainder of his benefit period. Alice meets her deductible in three months. She then purchases covered prescription drugs at the co-payment amounts for the remainder of her benefit period.

If only one spouse in a married couple is determined eligible, only his/her costs count toward the spenddown. S/he pays retail price for covered prescription drugs until the spenddown requirement is met.

Example 2: Tracy and Dave's annual income is $ 31,976, which is $2,000 more than 240% of the FPL for a FTG of two (5.16.7). Because Tracy is 63 years old, only Dave is eligible for SC. For the 12-month benefit period Dave's spenddown amount is $2,000.

Tracy and Dave pay for their covered prescription drugs at retail price. Only covered prescription drugs purchased for Dave count toward the spenddown requirement.

After Dave has met the $2,000 spenddown, he has a $850 deductible. Only covered prescription drugs purchased for Dave count toward his deductible.

After Dave meets his deductible, he purchases covered prescription drugs at the co-payment amounts for the remainder of her benefit period.

This page last updated in Release Number: 04-02
Release Date: 04/30/04
Effective Date: 04/30/04

5.16.8 Countable Costs

In order for the prescription drug purchase to count towards meeting a spenddown or deductible, it must be:

1. Prescribed for the eligible SC participant,

2. Purchased during the benefit period, and

3. Covered by the SC program (5.16.16).

All covered prescription drug costs the participant incurs will be tracked, and the SC Program will coordinate coverage with insurance companies. If the prescription is covered by insurance, only the portion not paid by insurance is applied toward the spenddown or deductible.

When a participant's out-of-pocket expense requirements are met for a deductible or spenddown, participating pharmacies will be informed.

5.16.8.1 Carryover

There is no carryover of prescription costs from one benefit period to the next. There are two instances, **within a benefit period**, when carryover covered prescription amounts are applied.

1. When the covered prescription cost exceeds the remaining deductible amount, SC pays the difference.

Example 1: Jeff earns between 160% and 200% of the FPL for a FTG size of one (8.1.14). He is eligible for SC and has a $500 deductible. In three months, Jeff has a remaining deductible amount of $30. During the fourth month of his benefit period, with a $30 remaining deductible, Jeff purchases a covered prescription drug that costs $100. The pharmacist informs him that he owes $30 of the $100 prescription drug cost. He has met his deductible. The remaining $70 will be paid by SC. For the next prescriptions that Jeff has filled during his benefit period, he will pay only co-payment amounts.

2. When the cost of a covered prescription drug is applied toward meeting the spenddown and the amount exceeds the remaining spenddown amount, the excess will be applied toward the deductible.

> **Example 2:** Rachel earns $24,144, which is $1,800 more than 240% of the FPL for a FTG of one (8.1.14).. Her spenddown amount for the 12-month benefit period is $1,800. In four months Rachel has incurred all but $50 of her spenddown amount by purchasing covered prescription drugs at retail price.
>
> During the fifth month of her benefit period, when she has $50 of her spenddown left, Rachel purchases a covered prescription drug that costs $100. Rachel pays the full $100. Of the $100, $50 is applied to her spenddown, and $50 is applied to her deductible. She now has satisfied the spenddown, and the remaining deductible amount is $800.

5.16.8.2 Date of Purchase

A prescription is considered purchased on the date the prescription is filled. For the drug purchase to count toward either the spenddown or the deductible, the prescription must have been purchased during the benefit period.

This page last updated in Release Number: 04-02
Release Date: 04/30/04
Effective Date: 04/30/04

5.16.9 Addition of a Spouse

The following exceptions apply when one spouse (hereafter referred to as Spouse 2) is determined eligible after the participating spouse's (hereafter referred to as Spouse 1) benefit period has begun.

In all of these situations, Spouse 1's eligibility and benefit period does not change, unless s/he chooses to reapply (5.16.11).

If Spouse 2 becomes eligible after Spouse 1's benefit period has begun, Spouse 2's benefit period ends on the same date that Spouse 1's benefit period ends.

The participation level for Spouse 2 depends on whether:

1. Spouse 2 was married and living with Spouse 1 at the time of Spouse 1's application (5.16.9.1).

    a. If spouse 1's eligibility was determined at level 2a or 2b, then refer to (5.16.9.1)

    b. If spouse 1's eligibility was determined at level 3 then refer to

(5.16.9.1.2)

- Met spenddown (5.16.9.1.2.1)
- Unmet spend (5.16.9.1.2.2)

Or

2. Spouse 2 was not included in the FTG (e.g. single or not living with Spouse 1) at the time of Spouse 1's application. (5.16.9.2), but the are now residing together.

   a. If spouse 1's eligibility was determined at level at level 2a or 2b, refer to (5.16.9.2.1)

   b. If spouse 1's eligibility was determined at level 3, refer to (5.16.9.2.2)

See Summary Table

5.16.9.1 Adding a Spouse No Change in FTG

If Spouse 2' s participation level is determined after Spouse 1's and Spouse 2 was included in the original FTG (married and living with Spouse 1 at the time of Spouse 1's application) the participation level for Spouse 2 is determined based on annual income information provided on Spouse 1's application.

Example: Tyler and Anne are married and live together. Tyler has significant prescription drug expenses and applies for SC. Anne takes no prescription drugs and does not request SC when Tyler applies in March. Tyler's participation level is based on a FTG of two. Tyler is found eligible, and his benefit period begins April 1st. In September, Anne is diagnosed with a health problem and begins taking prescription drugs. She applies for SC on September 15th. The same income information provided in March is used to determine Anne's eligibility, even though Tyler has since obtained a part-time job and has additional income. Anne's benefit period is from October 1st through March 31st so her benefit period ends at the same time as Tyler's. They will report the income from Tyler's part-time job when their SC eligibility is reviewed in March.

5.16.9.1.1 Adding a Spouse, No FTG Change, At Levels 2a and 2b

Spouse 2's deductible is prorated if the couple's gross annual income is between 160% and 240% of the FPL, and Spouse 2 becomes SC eligible after Spouse 1's benefit period has begun. To prorate the deductible, multiply the required deductible amount ($500/$850) by the number of months in Spouse 2's benefit period and divide by 12.

Example: Mary and Jim apply for SC in January. They have an annual income of $22,000, which is between 160% and 200% of the FPL for a FTG of two (8.1.14). Their income places them in Level 2a ($500 deductible).

Jim is determined eligible for SC, but Mary's eligibility for SC is denied because she is 64. Mary is refunded her enrollment fee. Jim's 12-month benefit period begins February 1st. Jim has a $500 deductible.

In June, Mary will turn 65. At adverse action in the month of May, CARES will process this case through batch. At that time, the application status is updated if the applicant who is turning 65 is:

1. In an open SC case, **and**
2. The individual has requested SC.

A letter is sent to Mary notifying her that if she still wishes to participate in SC, she must submit her $30 annual enrollment fee. If Mary's enrollment fee is received before July 1st, she will be determined eligible beginning July 1st.

Mary's benefit period begins August 1st, and ends January 31st, when Jim's benefit period ends. Mary's deductible is prorated. Since there are six months in her benefit period, $500 is multiplied by six and the total is divided by 12.

$500 x 6=$3,000/12=$250

Mary's deductible is $250. Once Mary meets the $250 deductible by purchasing covered prescription drugs, she is eligible to purchase covered prescription drugs at the co-payment amounts through the remainder of her benefit period.

Jim's eligibility and benefit period are not affected. If the couple's income were between 200% and 240% of the FPL, the example would be the same except that the $500 deductible would be $850.

5.16.9.1.2 Adding a Spouse, No FTG Change, At level 3

If the couple's income is greater than 240% of the FPL and Spouse 2 becomes eligible after Spouse 1's benefit period has begun, the procedure differs according to whether the spenddown has been met at the time Spouse 2's eligibility begins.

5.16.9.1.2.1 Unmet Spenddown

When Spouse 2 is added before Spouse 1 has met the spenddown, covered prescription drug purchases of both spouses will count toward the remaining spenddown requirement.

After the spenddown has been met, both spouses begin to participate at Level 2b, and each will have a deductible requirement. The deductible for Spouse 1 is $850. The deductible for Spouse 2 is prorated (5.16.9.2.1).

Participants will get a discount off the retail price for most covered prescription drugs during the deductible period.

After a spouse has met his/her deductible, s/he purchases covered prescription drugs at the co-payment amounts for the remainder of the benefit period.

Example: Reginald and Elizabeth's joint income is $32,976, which is $3,000 more than 240% of the FPL for a FTG of two. Elizabeth applies in December and is determined eligible for SC effective January 1st. Only Elizabeth's covered prescription drug costs are applied toward the spenddown.

In March, Reginald turns 65 and is determined eligible for SC beginning April 1st. His benefit period ends December 31st, when Elizabeth's ends. Since Elizabeth has not yet met the spenddown when Reginald's eligibility begins, both spouses' covered prescription expenses are applied toward the remaining spenddown amount, beginning April 1st.

In June, Elizabeth and Reginald meet the spenddown. Elizabeth has a $850 deductible, but Reginald's deductible is prorated. Since there are nine months in his benefit period, $850 is multiplied by nine and the total is divided by 12.

$850 x 9 = $7,650/12 = $638

Reginald's deductible is $638. Once Reginald meets the $638 deductible, he purchases covered prescription drugs at the co-payment amounts through the remainder of his benefit period. Once Elizabeth meets her $850 deductible, she purchases covered prescription drugs at the co-payment amounts through the remainder of the benefit period.

5.16.9.1.2.2 Met Spenddown

When a second spouse is added after the spenddown has been met, the eligibility and benefit period for Spouse 1 is not affected.

If Spouse 2's income was included in Spouse 1's determination and the spenddown has been met, the deductible for Spouse 2 is prorated (5.16.9.2.1). Participants will get a discount off the retail price for most covered prescription drugs during the deductible period.

After a spouse has met his/her deductible, s/he purchases covered prescription drugs at the co-payment amounts for the remainder of the benefit period.

Example: Bob and Bernice's joint income is $ 30,976, which is $1,000 more than 240% of the FPL for a FTG of two. Bernice applies in December and is determined eligible for SC effective January 1st. Bob does not apply because he is not yet 65 years old. Only Bernice's covered prescription drug costs are applied toward the spenddown amount of $1,000.

Bernice meets the spenddown requirement in April. She then begins purchasing covered prescription drugs that count toward her $850 deductible. In June, she has $100 left before she will meet her deductible.

In May, Bob turns 65 and is determined eligible for SC. His eligibility begin date is June 1st. His benefit period ends December 31st, when Bernice's ends. Since Bernice has already met the spenddown requirement, Bob will begin participating at Level 2b. His deductible will be prorated. Since there are seven months in his benefit period, $850 is multiplied by seven and the total is divided by 12.

$$\$850 \times 7 = \$5{,}950/12 = \$496$$

Bob's deductible is $496. After he meets the $496 deductible by purchasing covered prescription drugs, he purchases covered prescription drugs at co-payment amounts for the remainder of his benefit period.

Bernice's eligibility and benefit period are not affected. Once she meets her deductible by purchasing another $100 in covered prescription drugs, she purchases covered prescription drugs at the co-payment amounts for the remainder of her benefit period.

5.16.9.2 FTG Changes

When a married SC participant applies after Spouse 1's benefit period has begun, and Spouse 2 was not included in the FTG when the participation level for Spouse 1 was determined:

1. The gross annual income test for Spouse 2 is based on a FTG of two, **and**

2. Gross annual income for Spouse 2 is determined prospectively beginning with the month Spouse 2's request is received, **and**

3. The eligibility and benefit period for Spouse 1 is not affected, unless s/he chooses to reapply.

Example: Jim is a SC participant from September through August. Because he was not married and living with a spouse when he applied, Jim's benefit level was based on a FTG of one.

In January Jim marries Helen. Helen applies for SC in February. Jim's eligibility is not re-determined when Helen applies.

Helen's participation level is determined based on a FTG of two. Income is estimated for Helen prospectively for the 12-month period beginning in February.

Helen's benefit period begins in March, if she met all eligibility requirements in February. Helen's benefit period ends in August, when Jim's benefit period ends.

5.16.9.2.1 FTG Changes at Level 2a and 2b

Spouse's 2 deductible is prorated (5.16.9.2.1) when income for Spouse 2, based on a FTG of two, is determined to be above 160% but less than or equal to 240% of the FPL and Spouse 2 is added to the case after Spouse 1's benefit period has begun.

Example: Will is married, but he and his wife Grace were separated at the time he applied for SC.

Will applies for SC in October. Will's benefit level is based on a FTG of one, using only his income. Will's gross annual income is $13,176, which is less than 160% of the FPL for a FTG of one.

Will is determined to be SC eligible at Level 1 beginning November 1st. His 12-month benefit period ends the following October. Will does not pay a deductible or spenddown. He purchases covered prescription drugs at the co-payment amounts.

Grace returns home in January. She applies for SC in February and is determined eligible beginning March 1st. Grace's benefit level is determined based on a FTG of two. Their joint income is determined to be $27,656, which is between 200% and 240% of the FPL for a FTG of two. Her benefit period ends October 31st, when Will's benefit period ends.

Since there are eight months in her benefit period, Grace's deductible amount is prorated. The deductible amount of $850 is multiplied by eight and then divided by 12.

$850 x 8=$6,800/12=$567

Grace's deductible amount is $567. After she has met her deductible, she purchases covered prescription drugs at the co-payment amounts for the remainder of the benefit period. Will's eligibility and benefit period are not affected.

5.16.9.2.2 FTG Changes At Level 3

Spouse 2's spenddown is prorated only if:

The income for Spouse 2, based on a FTG of two, is determined to be above 240% of the FPL, **and**

1. Spouse 2 becomes eligible after Spouse 1's benefit period has begun, **and**

2. Spouse 2 was not included in the FTG when the participation level for Spouse # 1 was determined.

To prorate Spouse 2's spenddown, multiply the amount of income exceeding 240% FPL by the number of months of Spouse 2's benefit period and divide by 12. The result is equal to the prorated spenddown amount of Spouse 2. Only covered prescription drug costs of Spouse 2 count toward the prorated spenddown.

After the spenddown has been met, the deductible for Spouse 2 is prorated (5.16.9.2.1). Participants will get a discount off the retail price for most covered prescription drugs during the deductible period.

After the deductible is met, s/he purchases covered remainder of the benefit period.

Example: Tim is married, but his wife Marsha was institutionalized at the time he applied for SC. Marsha was expected to be out of the home for five months.

Tim applies for SC in May. Tim's benefit level is based on a FTG of one. Tim's gross annual income is $13,176, which is less than 160% of the FPL for a FTG of one.

Tim is determined to be SC eligible beginning June 1st. His 12-month benefit period ends the following May. Tim does not pay a deductible or spenddown. He purchases covered prescription drugs at the co-payment amounts.

Tim's wife Marsha returns home in November. She applies for SC in November and is determined eligible beginning December 1st. Marsha's participation level is determined based on a FTG of two. Their joint income is determined to be $30,976, which is $1,000 above 240% of the FPL for a FTG of two. Her benefit period ends May 31st, when Tim's benefit period ends.

Since there are six months in her benefit period, Marsha's spenddown amount is prorated. The spenddown amount of $1,000 is multiplied by six and then divided by 12.

$1,000 x 6=$6,000/12=$500

Marsha's spenddown amount is $500. After she has met her spenddown, she then has a prorated deductible. Since there are six months in her benefit period, $850 is multiplied by six and then divided by 12.

$850x 6=$5,100/12=$425 Marsha pays for covered prescription drugs until she has met the $425 deductible. After Marsha has met the deductible, she purchases covered prescription drugs at the co-payment amounts for the remainder of benefit period. Tim's eligibility and benefit period are not affected

ADDITION OF A SPOUSE

The following table assumes that Spouse 1 and Spouse 2 do not apply for SC at the same time.

	SPOUSE 1's Eligibility	**SPOUSE 2's Eligibility**
Benefit Period: **Begin Date**	First of month following receipt of a valid application and enrollment fee.	First of month following receipt of a valid application and enrollment fee. Will be later than Spouse 1's begin date.
Benefit Period: End Date	End of twelfth month of eligibility unless terminated early.	Same end date as Spouse 1 regardless of when Spouse 2 applies.
Participation Level: Married at time of Spouse 1's application	FTG of two. Participation Level determined based on annual self-reported income of both spouses.	FTG of two. Participation Level determined based on annual self-reported income from Spouse 1's application. Eligibility results will be the same as Spouse 1.
Participation Level: Single or not living together at time of Spouse 1's application.	Gross annual income test based on a FTG of one. When adding a new spouse, Spouse 1 does not need to reapply until the end of the twelve-month benefit period unless s/he chooses to do so.	Gross annual income test based on a FTG of two. Participation Level determined based on annual self-reported income of both spouses. Participation Level may be different than Spouse 1's. Spouse 2 must estimate income at the time s/he applies. Spouse 1's income remains the same.
Deductible:	Has a $500/$850 deductible based on Participation Level.	Required deductible is prorated based on number of months of eligibility and amount of deductible.
Spenddown: Unmet Original FTG of 2	Covered prescription drugs of Spouse 1 used to meet spenddown until Spouse 2 is added. Once spenddown	Projected income from Spouse 1's application will be used to determine Spouse 2's eligibility.

	is met, Spouse 1 has a deductible of $850.	Covered prescription drugs of both spouses are used to meet the spenddown. Once spenddown is met, Spouse 2 has a prorated deductible.
Spenddown: Met Original FTG of 2	No change in spenddown for Spouse 1.	No new spenddown when Spouse 2 is added. Spouse 2 has a prorated deductible.
Spenddown: Unmet Original FTG of 1	No change in spenddown for Spouse 1.	Spouse 2 has a prorated spenddown and deductible.
Spenddown: Met Original FTG of 1	No change in spenddown for Spouse 1.	Spouse 2 has a prorated spenddown and deductible.

Note: If Spouse 1 terminates prior to spouse 2's request. A new application is required for a new 12- month benefit period.

This page last updated in Release Number: 04-02
Release Date: 04/30/04
Effective Date: 04/30/04

5.16.10 Changes

The following changes must be reported to the SC Program within ten days:

1. Address.
2. Household Composition (examples include marriage, divorce, separation)
3. Death.

Changes may be reported by phone to the SeniorCare Customer Service Hotline at 1-800-657-2038.

Changes may also be reported by writing to:
SeniorCare
P.O. Box 6710
Madison, WI 53716-0710

Participants are asked to include an SSN on any written correspondence.

If a participant reports any changes before the case has been confirmed in CARES, the new information will be used in his/her SC eligibility determination.

Changes reported after the case has been confirmed in CARES will be applied to the participant's SC benefits as follows:

1. Address change:

a. Reports of address changes within Wisconsin will result in SeniorCare notices being sent to the new address. SC benefit levels will not change for the current benefit period.

b. Address changes that result in termination of Wisconsin residency result in discontinuation of SC benefits. Provide the participant with at least 10 days notice before the effective date of an adverse action.

   Note: Reporting an out-of-state address does not necessarily signify that an applicant is not a Wisconsin resident (5.16.3).

2. Death

A participant's death ends SC eligibility on the date of death. A 10-day notice for adverse action is not required when an adverse action is the result of a participant's death. The "early termination date" for the participant should be equal to the participant's date of death.

If a participant's spouse dies, the participant will remain eligible at the same benefit level through the current SC benefit period. The participant may wish to re-apply to establish a new benefit level if the spouse's death will result in a reduction in income.

3. Change in household composition

If a participant experiences a change in household composition, the SC benefit level will not change through the remainder of the SC benefit period. The participant may wish to re-apply to establish a new benefit level if the change in household composition will result in a better level of participation.

4. Inmate of a public institution (1.1.2).

An inmate of a public institution is ineligible for SC on the date incarceration begins. Provide the participant with adequate notice before the effective date of the adverse action. The "early termination date" is equal to the notice mailing date.

If a participant's spouse is an inmate of a public institution the participant benefit level will remain the same through the current benefit period. The participant may wish to re-apply to establish a new benefit level if the spouse's incarceration will result in a better level of participation.

5. Change in Circumstance

An applicant who wishes to change or correct information on his/her submitted application may do so prior to eligibility being confirmed in CARES.

Depending on the nature of a client-reported error or agency discovered error, a participant's eligibility will be re-determined (5.16.10.1). Provide the participant with at least 10 days notice before the effective date of an adverse action. If the case has already been confirmed in CARES, the applicant may opt out and reapply if s/he so desires.

Example: Sally and Fred are husband and wife and applied for SC in July. Both Sally and Fred were found eligible with a deductible (Level 2a) for August. In September, Fred loses his job. He reports the change to the SC program. This change will not affect Sally or Fred's SC benefits, because Fred reported the change after his case had been confirmed in CARES. In order to have eligibility redetermined Fred and Sally will need to file a re-application (5.16.11) and submit enrollment fees for each. Without the income from Fred's job, Sally and Fred would be able to purchase prescription drugs at the co-payment level, if a reapplication is filed.

If Fred had reported the change prior to his case being confirmed in CARES, the change would have been applied to Sally and Fred's eligibility determination, and they would have paid the co-payment amounts for prescription drugs. If Fred and Sally wish, they may request to file a reapplication (5.16.11) to change their benefit level.

5.16.10.1 Correction of Errors

All errors made on the SeniorCare Application (HCF 10076) must be reported by the participant or his/her Authorized Representative, POA, or Guardian to the SeniorCare Customer Services Hotline at 1-800-657-2038 (TTY and translation services are available) or in writing to:

SeniorCare
P.O. Box 6710
Madison, WI 53716-0710

An error may include, but is not limited to:

1. Doubling of income (totaling income on the application).
2. Income amounts are off by a factor of 100. (lack of decimal)
3. Application processing errors.

An applicant who wishes to change/correct information on his/her submitted application may do so prior to eligibility being confirmed in CARES (5.16.10).

If a participant has been found eligible for either an incorrect SC benefit level or spenddown amount due to an error, action will be taken to correct the mistake. The effective date of the correction is based on whether the error is determined to be Agency Error or Applicant /Participant error, as follows:

5.16.10.1.1 Agency Error

Agency Error for SC will be determined on a case by case basis. If the error resulted in an overpayment, past benefits are not recoverable. If the error resulted in an underpayment, corrected benefits will be restored back to initial eligibility date of the benefit period.

5.16.10.1.2 Applicant/Participant Error

If the error resulted in an overpayment, benefit recovery will Error be pursued and the correction is processed with an effective date based on adverse action notice. Provide the participant with at least 10 days notice before the effective date of an adverse action.

If the error resulted in an underpayment and s/he reported the error within 45 days of the mail date of the notice of decision, restore corrected benefits back to the initial eligibility date of the benefit period. If the error is not reported within 45 days of the notice of decision mail date, the effective date of the correction is the first of the month in which the error is reported.

Example 1: In August, Charlie lost this job at the Burger Palace. In September Charlie applied for SC. In his application Charlie erroneously reported income of $1150 per month from the Burger Palace job., Charlie's notice of decision had a mail date of October 1, and stated that Charlie had a $1500 spenddown.

Depending on when Charlie reports this error his benefits may be corrected back to the eligibility begin date or the first month in which the error was reported. (5.16.10.1).

If he reported the error by November 15, within the first 45 days after the notice of decision mail date, his benefits would be corrected back to the original effective date.

If he reported the error November 16 or later (more than 45 days after the notice of decision mail date), the benefit level change would be made effective the first of the month in which the error was reported.

Example 2: Eric applied for SC in July and was determined eligible at level 1 effective August 1st. Prior to applying for SC, Eric got a part-time job that had begun in June. When Eric applied for SC, he neglected to report his anticipated part-time earnings on the SC application.

Eric receives his notice of decision, dated August 8th. The notice informs he is eligible at level 1. Eric reviews the income used in his eligibility determination that is printed in the notice. Eric realizes that he forgot to report his earnings from his part – time job and he calls the CS Hotline on August 21 to report his error.

Eric reports to the CS Correspondent that he is working 10 hours per week and earns $10 per hour. He plans to keep the job as long as possible. He estimates that his earnings will be $5200 for his 12-month benefit period. The only other income that Eric receives is Social Security. His earnings in addition to the annual Social Security income add up to an annual estimated income of $19,700. Or level 2b.

Since the income correction will result in a negative impact on his eligibility, the effective date of the corrective benefit is October 1, providing Eric with a 10-day notice of the negative action in his case.

Prior to reporting this mistake, Eric had purchased several prescriptions at the co-pay levels with his SC Card. Since the correction resulted in Eric's eligibility at level 2b, he must now meet an $850 deductible between October 1 and July 31 (the end of his 12- month benefit period), SC will have overpaid Eric's benefits and could seek recovery of the overpaid amount.

5.16.10.2 Fraud

Fraud is defined as intentionally getting or helping another person get benefits to which s/he is not entitled. Penalties for fraud include a fine of up to $10,000, imprisonment up to one year, or both, and suspension from the SC program.

Fraudulent acts include:

1. Intent to provide misleading, fraudulent, omitted, or incomplete information on the SC application;
2. Not reporting an event that knowingly affects initial or continued eligibility for SC;
3. Applying for SC on behalf of another person and use of any part of the benefit for oneself; **or**
4. Allowing another person to use someone else's card to get prescription drugs.

This page last updated in Release Number: 04-02
Release Date: 04/30/04
Effective Date: 04/30/04

5.16.11 Re-Application

SC participants may request to establish a new SC benefit period at any time. However, it is not beneficial for a SC participant to reapply unless s/he will experience a reduction in gross annual income. The reduction in annual income may occur for reasons varying from loss of income to household composition changes. This could result in SC eligibility at a lower income level resulting in a reduction/elimination of spenddown or deductible.

Such a change may result from divorce, marriage, institutionalization or death of a spouse, or any other change that results in a significant decrease in income.

To reapply, participants must submit a new application form and pay a $30 enrollment fee per person. Eligibility will be re-determined for a new 12-month period (within 30 days) after a complete application is received.

When eligibility for a new benefit period is determined, the participant's previous benefit period is terminated, and s/he is not allowed to restart the previous benefit period. Any expenses applied to the previous benefit period will not be applied to the new benefit period.

Eligibility for a new benefit period begins on the first day of the month after a complete application is received and all eligibility requirements are met.

This page last updated in Release Number: 04-02
Release Date: 04/30/04
Effective Date: 04/30/04

5.16.12 Early Termination

SC eligibility is terminated prior to the end of the established benefit period if:

1. A participant no longer meets non-financial eligibility requirements, **or**

2. S/he requests to withdraw from the program, **or**

3. S/he requests to establish a new benefit period **and** eligibility for the new benefit period is confirmed (5.16.11).

When SC eligibility has been terminated prior to the end of the established benefit period and the SC Program is notified that all eligibility requirements are again satisfied, within one calendar month of SC eligibility termination, the benefit period is restored.

Exception: SC participants who lose SC eligibility solely due to receipt of MA benefits do not have their benefit period terminated; however, they are not eligible for SC benefits or services for the calendar months that they receive MA benefits.

If MA eligibility ends prior to the end of the SC benefit period, and the participant is still SC eligible, SC eligibility automatically resumes.

Example: Amy applies for SC on October 4th and is determined eligible effective November 1st. In December she applies for MA and is determined eligible, effective December 1st. Amy is not eligible for SC benefits or services while she is receiving MA.

In January, Amy inherits $5,000 and is notified that her MA eligibility ends January 31st, because her assets exceed the limit. Amy still meets SC eligibility requirements, so SC eligibility will resume from February 1st through October 31st.

See 5.16.15 for termination as it applies to the need for an annual review.

5.16.12.1 Withdrawal

Applicants or participants may withdraw from the SC Program at any time. To withdraw by phone, call the SeniorCare Customer Service Hotline at 1-800-657-2038.

A request to withdraw can be made in writing to:

SeniorCare
P.O. Box 6710
Madison, WI 53716-0710

A SC participant is eligible for an enrollment fee refund only if s/he meets the requirements listed in 5.16.3.1.1.

If an applicant chooses to withdraw his/her application prior to eligibility confirmation, s/he will get a refund. If s/he later wishes to “opt in”, s/he will have to re-apply. To re-apply, a new application and enrollment fee are required.

Once eligible, if a participant chooses to “opt-out” and SC receives the request to withdraw within the timeframe for obtaining a refund, s/he will get a refund of the original enrollment fee. If, within thirty calendar days of opting out, the participant requests to opt in, s/he would need to send in another enrollment fee but would not have to send in another application form. Eligibility will be restored back to the beginning of his/her benefit period, once the fee is received and processed.

The enrollment fee must be received by the deadline identified in the CARES notice to comply with the administrative rule requirement that s/he meets eligibility requirements. If within thirty calendar days of opting out s/he does not contact SC and SC does not receive the enrollment fee, s/he will have to submit a new application and another $30 enrollment fee if s/he wants to come back into the program.

If the participant chooses to opt-out and does not do so within the timeframe for obtaining a refund, s/he will not get a refund. Customer Service should counsel the participant that s/he will not be getting a refund, and s/he can keep his/her case open in the event his/her circumstances change and s/he wants to use the SC benefit in the next 12 months.

If the participant still opts out, but contacts SC within thirty calendar days of opting out to request to opt in, the original enrollment fee that had not been refunded will be applied. S/he will not have to send in another application form. The person will be made eligible back to their original eligibility begin date for that benefit period. This requires a manual work-around because the system will require another $30 enrollment fee to be credited for CARES to process correctly.

This page last updated in Release Number: 05-01
Release Date: 01/11/05
Effective Date: 01/11/05

5.16.13 Notice of Decision

A written notice is sent to the applicant indicating SC certification, benefit reduction, denial, or termination.

The initial notice of decision will provide information regarding total income used for determining participant level. It will also provide the participant with information regarding spenddown, deductible and co-payment amounts.

For reductions, denials or terminations, the notice contains reasons for the action, with any supporting regulations. It also specifies the circumstances under which SC benefits will be continued if a hearing is requested.

SC participants will be notified of an adverse action at least 10 days prior to the effective date of adverse action, except under certain circumstances.

Timely notice requirements do not apply when:

1. A prescription drug billing must be reversed due to an incorrect billing, and that reversal results in a benefit or service change.

2. A participant chooses to withdraw from the program.

3. A participant requests to establish a new benefit period and eligibility for the previous benefit period is terminated (5.16.11).

4. A person is an inmate of a Public Institution.

5. Death of a participant.

This page last updated in Release Number: 04-02
Release Date: 04/30/04
Effective Date: 04/30/04

5.16.14 Appeals

SC applicants, participants or representatives may file an appeal by writing to the Division of Hearings and Appeals (DHA) when one of the following occurs and the action is not the result of a general program policy change:

1. An application is denied, or the person is denied the right to apply.

2. An application is not acted upon within thirty calendar days.

3. A participant believes that the benefits s/he received, or the initial eligibility date of program benefits were not properly determined.

4. Program benefits are reduced, discontinued, suspended, or terminated.

An appeal may result in a hearing.

5.16.14.1 Requesting a Hearing

The SC applicant or participant, or his/her representative, may request a hearing. The request for a hearing must be made in writing to the DHA within 45 days from the effective date of the adverse action.

Benefits will be continued only if the participant requests a hearing prior to the effective date of the adverse action.

Hearings may be requested by writing to:

Wisconsin Department of Administration
Division of Hearings and Appeals
PO Box 7875
Madison, WI 53707-7875

5.16.14.2 Hearing

The hearing will be held at a location determined by the DHA.

Hearings will be:

1. Held at a time reasonably convenient to the petitioner, department or

agency staff and the administrative law judge.

2. Reasonably accessible to the petitioner.

3. Held on department or agency premises, subject to the judgement of the administrative law judge.

4. Accessible to those in need of accommodations for a disability or translation. (For information about an accommodation for a disability or translation for a hearing, call 1-608-266-3096 (voice) or 1-608-264-9853 (TTY).)

This page last updated in Release Number: 04-02
Release Date: 04/30/04
Effective Date: 04/30/04

5.16.15 Annual Eligibility Review

An annual eligibility review is required for each participant by the end of the current 12 month benefit period, to prevent a gap of in coverage. Eligibility for a new benefit period begins on the first day of the month immediately following the end of the previous benefit period when:

1. A valid pre-printed CARES renewal application or new application form (HCF 10076) is received by the end of the current benefit period, **and**

2. All eligibility requirements are met, including payment of the $30 annual enrollment fee.

Note: For the definition of “valid,” see 5.16.2.1.

This page last updated in Release Number: 04-02
Release Date: 04/30/04
Effective Date: 04/30/04

5.16.16 Benefits

For all of the participation levels, SC allows the following:

1. The generic form of any covered prescription drug, unless the medical practitioner writes on the prescription that the brand name form of the covered prescription drug is medically necessary.

2. Insulins are the only general category of over-the-counter drugs that are covered.

3. For levels 1 and 2a all prescription drugs covered by Medicaid. Some

limitations apply to prescription drug coverage for levels 2b and 3 if a rebate agreement has not been signed by the drug manufacturer.

4. Chemotherapy drugs that are FDA approved and the manufacturer has signed a rebate agreement.

Reimbursement for most drugs is limited to a 34-day supply. Some maintenance drugs may be provided in a 100-day supply.

The co-payment amount is not affected by the # of days in the supply.

NOTE : The participant should contact his/her provider to verify that SC covers a specific drug.

SC does not cover the following:

1. Prescription drugs administered in a physician's office.

2. Prescription drugs that are experimental or have a cosmetic, not a medical purpose.

3. Over-the-counter drugs (except for insulin) such as vitamins or aspirin, prilosec OTC, even with a prescription.

4. Prescription drugs for which prior authorization has been denied.

5. Colostomy supplies and other durable medical supplies (DMS) even though they may need a prescription.

6. Prescription drugs for participants in Levels 2b and 3 for which a rebate agreement has not been signed by the manufacturer.

5.16.16.1 Discount Pricing

The discount for a particular drug during the deductible period will be the same at every pharmacy. During the deductible period, the pharmacy must use the SC allowed price.

Exception: If a pharmacy's usual and customary charge is less than the SC allowed amount, then the participant would be charged the usual and customary charge and this amount will apply to SC spenddown and/or deductible.

5.16.16.2 Early Refills

When the participant is temporarily leaving the state and the supply on his/her prescriptions is insufficient, s/he will need to make arrangements with the pharmacist to have any additional refills mailed or have someone else pick-up the refill. Postage costs are not covered by SC nor do they count toward the deductible and/or spenddown. Requests for early refills will be denied.

5.16.16.3 Out-of-state Pharmacies

In an emergency, a participant can get a prescription filled out of state and have it count toward SC as long as the participant is within the US, Canada, or Mexico and the pharmacy completes the necessary forms.

Out-of-state pharmacies should contact 1-800-947-9627 to file a claim for reimbursement. Non-emergency prescriptions will be covered only when prior authorization has been granted.

This page last updated in Release Number: 04-02
Release Date: 04/30/04
Effective Date: 04/30/04

5.17 WISCONSIN WELL WOMAN MA

5.17.1 INTRODUCTION

5.17.1.1 Wisconsin Well Woman Medicaid

Wisconsin Well Woman Medicaid, administered by the Division of Health Care Financing (DHCF) provides eligible women with access to full-benefit Medicaid (MA) services.

5.17.1.2 Wisconsin Well Woman Program (WWWP)

The Wisconsin Well Woman Program (WWWP) is administered by the Division of Public Health (DPH), and is not MA. WWWP provides eligible women with various health screenings (including breast and cervical cancer screening), referrals, education, and outreach

WWWP performs the financial and initial non-financial screening for Wisconsin Well Woman Medicaid. The woman must have a health screening diagnosis, and need for treatment for breast or cervical cancer through WWWP to be considered for Wisconsin Well Woman Medicaid.

This page last updated in Release Number : 02-03
Release Date: 07-01-02
Effective Date:07-01-02

5.17.2 NON-FINANCIAL REQUIREMENTS

The following are Wisconsin Well Woman Medicaid specific non-financial requirements:

1. Meet general MA non-financial requirements (1.1.2).

2. Be at least 35 years old but under age 65.

3. Have been screened for breast or cervical cancer by WWWP

4. Be diagnosed for breast or cervical cancer, or certain pre-cancerous conditions of the cervix, as identified by the screener.

5. Require treatment for the breast or cervical cancer, or certain pre-cancerous conditions of the cervix, as identified by the screener.

6. Not be eligible for any other subprogram of MA, including BadgerCare.

7. Meet the insurance coverage requirements listed below in 5.17.2.1.

5.17.2.1 Disqualifying Insurance Coverage

A woman is ineligible for Wisconsin Well Woman Medicaid if she is covered by any one of the following:

1. Group health plans.
2. Health insurance.
3. Medicare Parts A or B.
4. Any other category of MA.
5. Veteran's benefits/CHAMPUS.
6. HIRSP.
7. Federal employee health plans.
8. Peace Corps health plans.
9. Other private or public health care plans.

5.17.2.2 Non-Disqualifying Insurance Coverage

1. The following health care benefits do not disqualify a client from Wisconsin Well Woman Medicaid:

   a. Coverage only for accident, or disability income insurance, or any combination thereof.

   b. Liability insurance, including general liability insurance and automobile liability insurance.

   c. Workers' compensation or similar insurance, credit-only insurance.

   d. Coverage for on-site medical clinics.

   e. Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

   f. Indian Health Services.

   g. Non-coverage of cancer treatment due to waiting period.

2. Separate health insurance benefits that are not considered health insurance if offered separately are:

   a. Limited scope dental or vision benefits.

   b. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

3. Independent uncoordinated benefits are not considered health care insurance if offered as independent and/or uncoordinated benefits (e.g., coverage only for specified disease or illness, hospital indemnity or other fixed indemnity insurance.

4. Separate insurance policies are not considered health insurance if offered as a separate insurance policy:

   a. Medicare supplemental health insurance.
   b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10.
   c. Similar supplemental coverage under a group health plan.

However, Medicare Parts A or B disqualify a client from Wisconsin Well Woman Medicaid eligibility.

5.17.2.3 Family Planning Waiver participants

Women enrolled in Family Planning Waiver who meet the following criteria, (regardless of age) will be eligible for Wisconsin Well Woman Medicaid. These are woman who:

- Are screened for, and diagnosed with, cervical cancer or a precancerous condition of the cervix,

  OR

- Receive a clinical breast exam through FPW and through follow up medical testing independent of the FPW are diagnosed with breast cancer.

  AND

- Are found to be in need of treatment for breast or cervical cancer or precancerous cervical condition and do not have other insurance that would cover the cancer treatment.

This page last updated in Release Number : 05-01
Release Date: 01-11-05
Effective Date: 01-11-05

5.17.3 FINANCIAL REQUIREMENTS

Do not test for assets or income. Financial requirements are addressed through the WWWP enrollment process.

This page last updated in Release Number: 02-03
Release Date: 07-01-02
Effective Date: 07/01/02

5.17.4 WISCONSIN WELL WOMAN PROGRAM

WWWP Local Coordinating Agencies perform most of the basic non-financial and financial data gathering, review, and verification before referring the woman to a provider for a health screening. The WWWP screener and/or providers will:

1. Complete and sign DPH 4818 with the assistance of the client prior to the health screening.

2. Perform a health screening, and complete HCF 10075 with a diagnosis and an indication of whether or not treatment is required.

3. Identify in the HCF 10075 “Comment” section the beginning and end dates of the presumptive eligibility (PE) for Wisconsin Well Woman Medicaid (5.17.5)

4. Explain that the duration of the client’s PE for Wisconsin Well Woman Medicaid will conclude at the end of the following calendar month.

5. Provide the client with a copy of the signed HCF 10075 and DPH 4818 forms. Forward a copy of the HCF 10075 to the WWWP Local Coordinating Agency.

The Local WWWP Coordinator should then fax a copy of the completed HCF 10075 to EDS at (608) 221-8815 within five days of the diagnosis date. EDS will enter the PE data in MMIS (with a medical status code of CB) and send the client a Forward card with the PE dates activated on the card.

This page last updated in Release Number: 02-03
Release Date: 07/01/02
Effective Date: 07/01/02

5.17.5 WISCONSIN WELL WOMAN MEDICAID

PE for Wisconsin Well Woman Medicaid is available for women if the provider performing the health screening is a certified MA provider. The provider doing the medical screening enters the PE dates in the “Comments” section on the HCF 10075. The dates should cover the time period from the date of diagnosis through the last day of the following calendar month.

The client may receive services by presenting both of the following completed forms to any MA provider:

1. WWWP Enrollment Form (DPH 4818).

2. Wisconsin Well Woman Medicaid Determination Form (HCF 10075).

To continue receiving Wisconsin Well Woman Medicaid, the client must apply at the local Economic Support Agency (ESA). If the client does not apply, the client’s MA benefits will terminate at the end of the month following the month of diagnosis.

The Local WWWP Coordinator faxes the completed HCF 10075 to EDS. EDS will record the dates of the PE in MMIS and issue the client a Forward card. ES workers cannot deny or close the PE segment before the end date established by the WWWP healthcare provider.

There is no limitation to the number of PE segments that the client can have for Wisconsin Well Woman Medicaid.

This page last updated in Release Number: 02-03
Release Date: 07/01/02
Effective Date: 07/01/02

5.17.6 APPLICATION

To apply for Wisconsin Well Woman Medicaid, through the Wisconsin Well Woman Program, the client must send or bring the completed DPH 4818 and HCF 10075 forms to her local ES agency. The client may apply for Wisconsin Well Woman Medicaid at any time after the client’s WWWP screening diagnosis. ES may only back-date the client’s eligibility to the first of the month up to three months prior to the application date, or the first of the day after the date of diagnosis occurs, whichever is later.

Use the two forms listed in 5.17.5 in place of the standard application forms. Do not enter the woman's information into CARES for purposes of Wisconsin Well Woman MA eligibility, as the program requires manual determination.

The date of receipt of the HCF 10075 is the filing date. Use the verification policy listed in chapter 1.2 for any items requiring verification.

Complete the following steps to certify a client for Wisconsin Well Woman Medicaid:

1. Review DPH 4818 for a "No" answer to the following questions:

    a. Does the client have any health insurance? (Item #32)

        If the client answers "Yes," determine if the insurance is one of those listed in 5.17.2.1. If "Yes," the woman is ineligible for Wisconsin Well Woman Medicaid. Refer her to the WWWP, and send a manual negative notice.

    b. Does the client have Medicare Part B? (Item #33)

        and

        Ask the client if she has Medicare Part A.

        If the client answers "Yes" to either of the other questions, the client is ineligible for Wisconsin Well Woman Medicaid.

2. Review DPH 4818 to ensure that the following fields have been completed: 1-5, 9-13, 16-25, 27-45.

    If the form is incomplete, request that the client provide any missing information. If the client does not provide all necessary information, there may be a delay in benefits.

3. Review HCF 10075 for a SSN. If the SSN is missing from HCF 10075 and is not present on DPH 4818 (#6a), ask the client to provide her SSN and enter it on HCF 10075. Providing an SSN for the WWWP is voluntary, but providing a SSN, or applying for one, is required for Wisconsin Well Woman Medicaid.

    If the client fails to provide a SSN, or fails to apply for a SSN (IMM, Ch. I, Part C, 8.4.3.1) within the 30-day application processing time or within ten days (whichever is later), send a manual negative notice to the client indicating that the she is not eligible for Wisconsin Well Woman Medicaid.

4. Ask the client if she is a citizen.

    If the client is not a citizen, ask her what her alien status is and to provide her alien registration card. Verify that the client is in a qualified alien status using the SAVE system (IMM, Ch. I, Part D, 4.0.0).

Note: Some clients with breast and cervical cancer who do not meet the immigration-related eligibility criteria may be eligible to receive emergency services. If a non-qualifying alien has been screened for WWWP, determine her eligibility for emergency services using the criteria in 3.2.3.

5. If there are any questionable items, contact the WWWP Local Coordinating Agency.

6. Submit a HCF 10110 (formerly DES 3070) with a medical status code of “CB” to certify any client who has met the criteria listed above. Submit the completed HCF 10110 to EDS through one of the following methods:

   a. Mail:

      EDS Attn: Eligibility Lead Worker WWWMA
      6406 Bridge Rd
      Madison, WI 53716

   b. E-mail: eds_3070@dhfs.state.wi.us

      When submitting an e-HCF 10110 (formerly DES 3070), enter “ Attn: Eligibility Lead Worker WWWMA” in the “Comments” section.

   c. FAX: (608) 221-8815

7. Certify the client for 12 months from the filing date and backdate to whichever is more recent:

   a. Up to three months prior to the filing date, or

   b. To the first day of the month in which the date of the diagnosis occurs (HCF 10075), or

Note: Only for women entering WWWMA through the Wisconsin Well Woman Program backdate to the day following the diagnosis date.

> **Example:** Sherry is diagnosed with cervical cancer on May 16, 2002. The WWWP healthcare provider certifies Sherry for Wisconsin Well Woman Medicaid PE from May 16, 2002 through June 30, 2002.
>
> Sherry applies for Wisconsin Well Woman Medicaid on May 5, 2002. ES certifies her for Wisconsin Well Woman Medicaid from May 1st through April of the following year.

ES sends Sherry a notice by March 17, 2003 indicating that her review is due by the end of April 2003.

If the client applies during her PE Wisconsin Well Woman Medicaid period, and you are not able to process her application within the 30-day processing time frame, extend her eligibility for an additional 30 days from the last day of her Wisconsin Well Woman Medicaid PE (HCF 10075 “Comments” section) with a medical status of “CB.”

To contact the Local Coordinating Agencies refer to #27 of DPH 4818.

5.17.6.1 Applications for Wisconsin Well Woman Medicaid by Family Planning Waiver participants

A Wisconsin Well Woman Medicaid Determination form (HCF 10075) submitted by a FPW participant is a request to enroll in WWWMA and dis-enroll in FPW.

Women 15-44 years of age, enrolled in FPW in CARES who meet the following criteria, will be eligible for WWWMA. These are women who:

- Are screened for, and diagnosed with, cervical cancer or precancerous condition of the cervix through the FPW.

or

- Receive a clinical breast exam through FPW and through follow up medical testing independent of the FPW are diagnosed with breast cancer.

and

- Are found to be in need of treatment for breast or cervical cancer or a precancerous cervical condition as determined by their physician.

\This page last updated in Release Number : 05-01
Release Date: 01/11/05
Effective Date: 01/11/05

5.17.7 CHANGES

Terminate eligibility, using adverse action logic, if the client:

1. Reaches the age of 65 years.

2. Moves out of state.

3. Reports that she no longer needs treatment for breast or cervical cancer.

4. Obtains health insurance or another type of MA.

   Send a manual negative notice to the client if one of these changes is reported, indicating that she is no longer eligible for Wisconsin Well Woman Medicaid. At this point test her through CARES for any other MA eligibility.

This page last updated in Release Number: 04-01
Release Date: 02/27/04
Effective Date: 02/27/04

5.17.8 REVIEWS AND RECERTIFICATIONS

Reviews/recertifications (2.2.2.1) are required every 12 months after the initial eligibility determination at the client's Wisconsin Well Woman Medicaid enrollment date. A review for Wisconsin Well Woman Medicaid only consists of receiving an updated HCF 10075 Wisconsin Well Woman Medicaid Determination (Refer to Example in 5.17.6)

Each local agency must develop a manual method for scheduling and tracking reviews. Notify the client 45 days before a review is due, and indicate what materials or information to send or bring with her.

Note: In order to eliminate unnecessary reviews, a best practice is to check MMIS to be sure that the recipient has not become certified for another type of full benefit MA (for example SSI MA), turned 65 years of age (or will turn 65 in the next twelve months), or become eligible for Medicare, Part(s) A, B or both, prior to notifying the recipient that a review is due.

Like other MA subprograms, the client has the option of responding to the review process by mail, phone, or in person.

At review, the recipient must provide a newly completed WWWMA form HCF 10075 indicating she is still in need of treatment for breast or cervical cancer, as certified by a physician.

ES should ultimately get a copy of the HFC 10075 designated "ES" at the bottom. Send a manual positive notice if all requirements are met.

Send a manual negative notice at least ten days prior to the case closing if the woman does not provide HCF 10075 or reports one of the changes listed in 5.17.7.

This page last updated in Release Number : 05-01
Release Date: 01/11/05
Effective Date: 01/11/05

Non-MA Related Subprograms

5.18 CARETAKER SUPPLEMENT (CTS)

5.18.1 CARETAKER Supplement

The Caretaker Supplement (CTS) Handbook was issued on December 20, 2004. The CTS Handbook is now available at the following website http://dhfs.wisconsin.gov/ssi/CaretakerHandbook/index.htm

This page last updated in Release Number : 05-01
Release Date : 01/11/05
Effective Date : 01/01/05

6 ONGOING CASE MANAGEMENT

6.1 ESTATE RECOVERY

6.1.1 ESTATE RECOVERY PROGRAM DEFINITION

The state seeks repayment of certain correctly paid home Program Definition health and long-term care benefits by:

1. Liens against a home
2. Claims against estates
3. Affidavits
4. Voluntary recoveries

These procedures are the Estate Recovery Program (ERP). No ERP recovery may be made for MA services provided before 10-01-91.

This page last updated in Release Number : 01-01
Release Date: 01/01/01
Effective Date: 01/01/01

6.1.2 RECOVERABLE SERVICES

Not all services provided by MA are recoverable. Recoverability depends on what was provided and the client's age and residence when s/he received the benefit.

Following are the services for which ERP may seek recovery:

1. All Medicaid services received while living in a nursing home on or after October 1, 1991.

2. All Medicaid services received while institutionalized in an inpatient hospital on or after July 1, 1995.

3. Home health care services received by clients age 55 or older on or after July 1, 1995 consisting of:

   a. Skilled nursing services.
   b. Home health aide services.
   c. Home health therapy and speech pathology services.
   d. Private duty nursing services.
   e. Personal care services received by clients 55 or older on or after April 1, 2000.

4. All home and community-based waiver services (COP Waiver, CIP 1A, CIP 1B, CIP II, Brain Injury Waiver and Community Supported Living Arrangements) received by clients age 55 or older on or after July 1, 1995 and:

   a. Prescription/legend drugs received by waiver participants.
   b. Benefits paid associated with a waiver participant's inpatient hospital stay. These include inpatient services that are billed separately by providers and Services that are non-covered hospital services.

5. In pilot counties, Family Care services received by clients age 55 or older on or after February 1, 2000 and:

   a. Prescription/legend drugs received by waiver participants.
   b. Benefits paid associated with a waiver participant's inpatient hospital stay. This includes inpatient services that are billed separately by providers and that are non-covered hospital services.

6. Costs that may be recovered through a lien are:

   a. Medicaid costs for services received on or after October 1, 1991 during a nursing home stay.

   b. Medicaid costs of all other recoverable services as listed in Items 1-5 that are received on or after April 1, 2000 by clients 55 or older as of the date of the service.

6.1.2.1 QMB

Payments for the Qualified Medicare Beneficiary (QMB) Medicare Part B premiums are not recoverable through ERP.

QMB co-payments and deductibles paid by Medicaid are recoverable through ERP. They are only recoverable if the co-payment or deductible was used to pay for a Medicaid service that is recoverable.

This page last updated in Release Number : 01-01
Release Date: 01/01/01
Effective Date: 01/01/01

6.1.3 NURSING HOME DEFINITION

For ERP purposes, "nursing home" is a place that provides 24-hour services, including room and board, to three or more unrelated residents who, because of their mental or physical condition, require nursing or personal care more than seven hours a week. This includes skilled nursing (SNF) and intermediate care facilities (ICF), in-patient psychiatric facilities and facilities for the developmentally disabled (FDD). “Nursing home” does **not** include:

1. A convent or facility owned or operated exclusively by and for members of a religious order that provides reception and care or treatment.

2. A hospice, as defined in §50.90(1) Wis. Stats., that directly provides inpatient care.

3. Community Waiver residence.

4. Institutions for mental disease (IMD) .

This page last updated in Release Number : 01-01
Release Date: 01/01/01
Effective Date: 01/01/01

6.1.4 LIENS

DHFS will not file a lien on:

1. Nonhome property.
2. Life estates.
3. Homestead property sold by land contract.
4. Property outside Wisconsin (See 6.1.4.2).
5. A mobile home or the land it sits on when the client does not own the land.

DHFS may file a lien on:

1. A home and all property used and operated in connection with that home.
2. A mobile home and the land it sits on, when the client owns the land.
3. A home placed in a revocable trust (See 6.1.4.8).

When a home is sold, DHFS uses the lien to recover certain payments for MA services provided as listed in 6.1.2. The lien’s value is “open ended.” The lien’s value increases as the amount of recoverable MA services paid accumulates.

Payment of the lien is made directly to DHFS. Do not accept any payments relating to liens filed by DHFS.

Contact the ERP Liens Specialist if the client’s home is sold within 45 days after the Notice of Intent to File a Lien is completed.

The lien has no effect until filed.

Example: Mr. A applies for MA on 03-06-95. He has a home and his circumstances require a lien. The ES agency sends a Notice of Intent to File a Lien on 03-10-95. ERP staff can not file a lien until 04-24-95 because of the required 45 day waiting period. Mr. A's legal representative sells the property on 04-10-95. Recovery of Mr. A's MA payments by a lien on that property is not possible as the property was sold before a lien was filed. The ESA contacts the ERP Lien Specialist to report on the home's sale.

6.1.4.1 Notice of Intent to File a Lien

Complete a Notice of Intent to File a Lien (HCF 13038) when an MA client meets **all** the following criteria. S/he:

1. Lives in a nursing home or inpatient hospital and is required to contribute to the cost of care.
2. Has a home (4.5.1).
3. Is not expected to return to live at that home.

   Base this decision on the person's medical condition. His/her physician's statement that s/he can reasonably be expected to return home is sufficient support for the person's claim that s/he will return.

   The physician's statement should include a description of the diagnosis and prognosis for the client. A form asking for a physician to merely indicate by checking a box, etc., that there is a reasonable expectation that the institutionalized individual will return home is not acceptable or sufficient. Allow the physician a reasonable amount of time to provide this information.

   When there is contradictory information (from a nursing home social worker, discharge planner, etc.) concerning the reasonable expectation of returning home, or you question the reasonableness of the statement by the client, family, guardian, power of attorney, or physician, that the person will return home, consult with the Estate Recovery Program's Lien Specialist. Do NOT file a Notice of Intent to File a Lien until ERP staff have checked with the Department of Health and Family Services' medical consultants. If ERP determines there is not a reasonable expectation, ERP will send you a letter listing the reasons for this decision. At that point, if all of the other conditions described in this section are met, file the Notice of Intent to File a Lien.

4. None of these relatives of the client reside in that home.

   a. Spouse.
   b. Child who is:

      - Under age 21, or
      - Blind, or
      - Disabled.

c. Sibling, if the sibling:

   - Has an equity interest in the home; **and**
   - Lived in the home continuously beginning at least 12 months before the client's nursing home or hospital admission.

When you have completed the Notice:

1. Mail or give the original to the client or his/her authorized representative.

2. Send a copy to the ERP office.

3. Attach a legible copy of the latest property tax bill or a copy of the property deed (if available) for any homestead property reported. This gives ERP staff the information necessary to obtain the legal description needed to file a lien.

4. File a copy in the case record.

ERP staff delays further action until the period given the client to request a fair hearing passes. If no hearing is requested, ERP staff will file a lien on the property with the Register of Deeds for the county in which the property is located. If a hearing is requested, a lien is not filed until approved by a hearing decision.

6.1.4.2 Out of State Property

If an MA client has property outside Wisconsin that would be subject to a lien if located in Wisconsin, provide the same data you would provide on Wisconsin property. Do not give a Notice of Intent to File a Lien.

DHFS may not file liens against out-of-state properties. However, ERP staff wants data on these cases to assist in negotiating lien agreements with other states.

6.1.4.3 Returns Home to Live

If, despite expectations, the resident is discharged from the nursing home or inpatient hospital, to return home to live, the lien must be released. Notify the ERP. ERP staff will release the lien.

6.1.4.4 Change in Circumstances

At review and other times, at local option, reexamine the circumstances (See 21.4.0) of the client's home. If conditions change such that a lien must be filed, complete a Notice of Intent to File a Lien.

6.1.4.5 Special Cases

ERP staff applies special consideration for the following two case situations:

1. When a child (age 21 or older) of the client lives in the home, DHFS is able to file a lien. It will not enforce the lien until that child moves or the home is sold if s/he:

   a. Lived in the home with the client for at least two years before the resident's admission to the nursing home or hospital, and
   b. Assisted the parent such that s/he helped delay the client's admission.

2. When a sibling of the client (other than a sibling described in 21.4.1) lives in the home, DHFS is able to file a lien. It will not enforce the lien until that sibling moves or the home is sold if the sibling resided in the home for at least 12 months before the client's admission to the nursing home or hospital.

Alert the ERP when your client meets either of these two case situations.

6.1.4.6 Adjustment for Burial Trust

DHFS may adjust the amount of its lien to allow a client to use proceeds from the sale of the home to establish or supplement a burial trust. ERP staff will review each situation individually. Refer any questions regarding lien satisfaction amounts or lien releases to the ERP staff.

6.1.4.7 Administrative Hearing: Liens

A client or his/her representative may request an administrative hearing if s/he feels the statutory requirements for imposing the lien have not been met. The Economic Support Agency (ESA) attends the hearing to explain the decision to file the Notice of Intent to File a Lien. The only issue at the hearing will be whether the following requirements were satisfied:

1. The client has an ownership interest in a home.
2. The client resides in a nursing home or hospital.
3. The client cannot **reasonably** be expected to be discharged from the nursing home or hospital and return home to live.
4. None of the following lawfully reside in the home:

   a. The client's spouse.
   b. The client's child who is:

      - Under age 21, or
      - Disabled, or
      - Blind.

c. The client’s sibling who has an ownership interest in the home and who has lived in the home continuously beginning at least 12 months before the client was admitted to the nursing home or hospital.

The request for an administrative hearing must be made in writing directly to the Division of Hearings and Appeals (DHA) at:

Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

The request must be clearly marked “Medicaid Lien” and must be filed within 45 days of the mail date on the Notice of Intent to File a Lien. The date the written request is received by DHA is the date the hearing request is considered filed.

6.1.4.8 Homes Placed in Revocable Trusts

If a MA client places his/her home in a revocable trust (4.5.1); s/he retains an ownership interest in the home. Complete a Notice of Intent to File a Lien if the client meets the conditions for a lien to be filed (See 6.1.4.1).

This page last updated in Release Number : 01-01
Release Date: 01/01/01
Effective Date: 01/01/01

6.1.5 ESTATE CLAIMS

DHFS recovers MA benefit costs from the client’s estate. No claim is made on the client’s spouse’s estate for a MA client’s costs.

When DHFS learns of the death of a client, it files a claim at probate court in the amount of MA recoverable benefits.

The probate court will not allow a claim on the estate to be paid if any of the following survives the client:

1. A spouse.
2. A child, if the child is:

    a. Under age 21, or
    b. Blind, or
    c. Disabled.

Do not negotiate a settlement, accept any funds, or sign any release for estate claims that have been filed by DHFS. ERP staff should be notified if

a claim is filed by the county against an estate for recovery of overpayments or incorrect MA benefits, for those 55 years of age or older or for any client who has resided in a nursing home.

Refer any questions about specific estate claims to the ERP staff.

6.1.5.1 Waiver of Estate Claim

In estates of clients who die on or after April 1, 1995, an heir or beneficiary of the deceased client's estate may apply for a waiver of an estate claim filed by ERP. To be successful, the person applying for the waiver must show one of these three hardships exist:

1. The waiver applicant would become or remain eligible for AFDC, SSI, FS or MA if ERP pursued the estate claim.

2. The deceased client's real property is part of the waiver applicant's business (for example, a farm) and the ERP recovery claim would affect the property and result in the waiver applicant's loss of his/her means of livelihood.

3. The waiver applicant is receiving general relief or veteran's benefits based on need under §45.351(1) Wis. Stats.

The waiver application must be made in writing within 45 days after the day:

1. ERP mailed its recovery claim to the probate court or its affidavit to the heir, or

2. ERP mailed its notice of waiver rights, whichever is latest.

The waiver application must include these points:

1. Relationship of the waiver applicant to the deceased client.

2. The hardship under which the waiver is requested.

ERP staff must issue a written decision granting or denying the waiver request within 90 days after the waiver application is received by ERP. In determining its decision, ERP must consider all information provided to it within 60 days of its receipt of the waiver application.

6.1.5.2 Notice of Hardship Waiver Rights

ERP will provide notice of the waiver provisions to the person handling the deceased client's estate. If ERP is not able to determine who that person is, the notice will be included with the claim when ERP files it with the claim court.

The person handling the estate is then responsible for notifying the decedent's heirs and beneficiaries of the waiver provisions.

6.1.5.3 Administrative Hearings: Hardship Waivers

If a waiver application is denied, the waiver applicant may request an administrative hearing. ERP staff will attend the hearing to defend their denial of the hardship waiver.

The hearing request must be made within 45 days of the date the ERP decision was mailed.
The hearing request must:

1. Be made in writing.
2. Identify the basis for contesting the ERP decision.
3. Be made to the Division of Hearings and Appeals (DHA) at:

    Department of Administration
    Division of Hearings and Appeals
    P.O. Box 7875
    Madison, WI 53707-7875

The date the request is received at DHA is used to determine the timeliness of the request.

ERP staff will maintain DHFS' claim in the estate pending the administrative hearing decision. If collections are made and the waiver is ultimately approved, those funds will be returned.

To introduce evidence at a hearing not previously provided to DHFS, the applicant must mail that evidence to DHFS with a postmark at least seven working days before the hearing date.

6.1.5.4 Personal Representative's Report

The personal representative of the estate of an MA client must notify DHFS that the estate is being probated [§859.07(2), Wis. Stats.]. The notification must be by certified mail and include the date by which claims against the estate must be filed.

6.1.5.5 Home as Part of the Estate

When a home **is part of the estate**, the court may impose a lien equal to the MA payments even if one of these persons is alive:

1. The spouse.
2. A child under age 21.
3. A disabled or blind child of any age.

Recovery through the lien will not be enforced as long as any of these persons meet the criteria and is alive.

Example: Mr. A dies. A claim on his estate is filed and the estate includes his home. His spouse is deceased and he has no blind or disabled child. He has a child, age 19. This child lives outside Mr. A's home. A lien is placed on the home but cannot be enforced because the minor child is still alive. The child later turns 21. As there is then no living spouse, child under 21, or disabled or blind child, the lien can be enforced.

DHFS will take a lien in full or partial settlement of an estate claim against the portion of an estate that is a home if:

1. A child, of any age of the deceased client:

    a. Resides in the client's home, **and**
    b. That child resided in that home for at least 24 months before the client entered the nursing home, hospital, or received home and community-based waiver services, and
    c. That child provided care that delayed the client's move to the nursing home, hospital, or his/her receipt of home and community-based waiver services.

2. A sibling of the deceased client:

    a. Resides in the client's home, and

b. Resided in that home for at least 12 months before the date the client entered a nursing home, hospital, or received home and community-based services.

The lien filed in one of these two instances will be payable at the death of the child or sibling or when the property is transferred, whichever comes first.

However, if the child or sibling sells the home covered by the DHFS lien, and uses the sale proceeds to buy another home to be used as that child's or sibling's primary residence, then:

1. DHFS will transfer the lien to the new home if the amount of the child or sibling's payment or down payment for the new home is equal to or greater than the proceeds from the original home.

2. If the down payment on the new home is less than the proceeds from the sale of the original home, DHFS will recover the amount of the proceeds above the down payment, but no greater than the lien amount. If there is an amount in the lien still not satisfied, DHFS will file a lien for the remaining amount on the new home.

6.1.5.6 Affidavits in Small Sum Estates

Heirs of a deceased MA client must notify ERP before transferring any of the deceased funds through a Transfer by Affidavit ($20,000 and Under) (§867.03, Wis. Stats.). The heir must send a copy of the affidavit to ERP by certified mail, return receipt requested. S/he must wait ten days from the delivery date on the return receipt card before transferring the deceased's funds. Property considered to be the home of a MA client who passed away after September 1, 2001 and is being transferred by an affidavit is subject to a lien if the state's claim cannot be satisfied through available liquid assets. The DHFS may not enforce the lien while any of the following survive:

1. Spouse,
2. Child who is:

a. Under age 21, or
b. Blind, or
c. Disabled.

If an heir claims the patient account fund or transfers the deceased's funds from a financial institution, ERP will send an affidavit to the heir to recover any funds remaining after burial and estate administration costs have been paid. Funeral costs are limited to those expenses connected with the funeral service and burial. A marker for the grave is considered a burial cost. Memorials and/or donations to churches, organizations, persons, or institutions are not considered burial costs.

ERP will recover any funds that remain from a burial trust after costs have been paid.

Direct specific questions about questionable allowable costs to ERP staff.

6.1.5.7 Patient Fund Account

Nursing homes are required to notify ERP when a MA client dies with money left in his/her nursing home patient fund account if s/he has no surviving spouse or minor or disabled child.

ERP will claim from the nursing home any funds remaining in the patient account after payment of funeral and burial expenses and outstanding debts from the last month of illness that are not chargeable to MA.

6.1.5.8 Voluntary Recovery (ERP)

When a client age 55 or older wishes to pay an amount to MA to maintain MA eligibility, prepay a MA deductible, or reduce a potential claim in an estate, forward the payment to ERP. First check, BVCI to make sure there is not an outstanding MA claim for an overpayment since the money should be applied to an overpayment first. Voluntary payments, except for prepayment of a deductible may only be up to the amount of MA paid to date. (See 6.1.10) for voluntary recoveries for clients under age 55.)

The check or money order should be made payable to DHFS.

Mail the payment to:

Estate Recovery
6406 Bridge Road
Madison, Wisconsin 53784-0013

With the payment, include:

1. Documentation that the payment is voluntary.
2. The client's name and MA ID number.
3. Name and address of the person who should receive the receipt.

These refunds will be credited to the client and will be used to offset any claim that may be filed in the client's estate.

Incentive payments of 5% will be paid to the ESA for refunds.

See the IMM, Ch. II, Part A, 3.2.0 for recovery of improper benefits.

Advise heirs and beneficiaries of deceased clients who wish to make a voluntary refund to call ERP staff.

This page last updated in Release Number : 01-01
Release Date: 01/01/01
Effective Date: 01/01/01

6.1.6 MATCH SYSTEM

ERP maintains the Estate Recovery Database. Information you submit on the Estate Recovery Disclosure Form and data received through the SSA State Data Exchange (SDX) tape (for SSI/MA clients) is on the database.

The database is compared to the death record files of the Division of Health Care Financing, Vital Records and State Registrar Section.

When a match shows an MA client or his/her surviving spouse has died, a report record is produced. ERP staff check the report against lists of new probate proceedings sent monthly by county registers in probate. This is a back up to the requirement that DHFS be notified of the last date for filing claims.

This page last updated in Release Number :01-01
Release Date: 01/01/01
Effective Date: 01/01/01

6.1.7 NOTIFY CLIENTS

Provide a copy of the Wisconsin Medicaid Estate Recovery Program brochure (PHC 13032) to every MA client 54 1/2 years old or older or institutionalized at application and review. Have each client or his/her representative read the notice of liability on the CAF ("Recovery of Medical Benefits"). S/he acknowledges understanding of this notice when signing the CAF.

This page last updated in Release Number : 01-01
Release Date:01/01/01
Effective Date: 01/01/01

6.1.8 DISCLOSURE FORM

Complete an Estate Recovery Program Disclosure Form whenever a MA client:

1. Enters or resides in a nursing home, or
2. Enters or resides in an inpatient hospital and is required to pay a MA cost of care liability, or
3. Becomes 55 years old.

Do this even if s/he has zero assets.

Complete the form with information about the client, his/her spouse, and his/her children that are blind, disabled, and under age 21.

Attach a legible copy of the latest property tax bill or a copy of the property deed for any homestead property reported if possible. This may give ERP staff the property's legal description needed to file a lien.

Request the client or his/her agent to sign the completed form. If s/he will not sign the form:

1. Sign the form at the "Client Signature" line.

2. Note near your signature that you reviewed the data with the person or his/her agent. Indicate:

a. That s/he did or did not agree the data was accurate.
b. The reason s/he did not sign.

In a mail-in application situation, document if the form was not returned or was returned without a signature.

Send the completed form to the ERP. File a copy in the case record.

Update this form unless there is a substantial change in circumstances (for example, an inheritance).

This page last updated in Release Number : 03-01
Release Date: 01/01/03
Effective Date: 01/01/03

6.1.9 ESTATE RECOVERY PROGRAM (ERP) CONTACTS

The ERP address is:

Estate Recovery Program Section
Division of Health Care Financing
P.O. Box 309
Madison, WI 53701-0309

For general information regarding ERP, refer clients to Recipient Services at 1-800-362-3002.

Direct case-specific questions about:

1. Estate recovery disclosure forms and liens to the Lien Specialist, (608) 264-6758.

2. For estates of $20,000 or less, provide the phone number of the “Affidavit Help Line,” (608) 264-6756, to heirs of a deceased clients who have questions about ERP. The Help Line provides recorded messages that answer the most frequently asked questions regarding small sum estates. It also provides the caller with an opportunity to either leave a message or talk to ERP staff.

3. Probated estate claims and voluntary ERP payments to the appropriate Estate Recovery Specialist. For the counties listed contact:

Estate Claims Specialists	
(608)264-6757	**(608)266-6777**
Bad River Tribal Calumet	Adams Ashland

Chippewa	Barron
Clark	Bayfield
Columbia	Brown
Crawford	Buffalo
Eau Claire	Burnett
Jackson	Dane
Jefferson	Dodge
Juneau	Door
Kenosha	Dunn
Kewaunee	Florence
Lac du Flambeau Tribal	Fond du Lac
LaCrosse	Forest
Lafayette	Grant
Langlade	Green
Lincoln	Green Lake
Milwaukee	Iowa
Racine	Iron
Richland	Manitowoc
Rock	Marathon
Rusk	Marinette
Sauk	Marquette
Sawyer	Menominee
Shawano	Monroe
Sheboygan	Oconto
St. Croix	Oneida
Stockbridge-Munsee Tribal Walworth	Oneida Tribal
Washburn	Outagamie
Washington	Ozaukee
Waukesha	Pepin
Waupaca	Pierce
Waushara	Polk
Winnebago	Portage
Wood	Price
	Red Cliff Tribal
	Taylor Trempeleau
	Vernon
	Vilas

This page last updated in Release Number : 02-03
Release Date: 07/01/02
Effective Date: 07/01/02

6.1.10 VOLUNTARY RECOVERY (NOT ERP)

Accept payments from a client **under age 55** made for purposes of MA eligibility or prepaying a MA deductible.

Instruct the client to make the payment payable to your ESA. Report the receipt on the Community Aids Reporting System (CARS) on Line 909.

This page last updated in Release Number : 02-03
Release Date: 07/01/02
Effective Date: 07/01/02

6.1.11 INCENTIVE PAYMENTS

DHFS will return to local agencies 5% of collections made through a lien, voluntary payments and probated estate recoveries. We will pay this incentive to the last county/tribal agency certifying the client for MA.

The payments are discretionary. DHFS will make them based on county/tribal compliance with program requirements.

This page last updated in Release Number : 02-03
Release Date: 07/01/02
Effective Date: 07/01/02

6.1.12 OTHER PROGRAMS

ERP also recovers for Community Options Program (COP), Wisconsin Chronic Disease Program (WCDP) and MA and non-MA Family Care.

This page last updated in Release Number : 02-03
Release Date: 07/01/02
Effective Date: 07/01/02

6.1.13 RECOVERABLE SERVICES CHART

	Nursing Home Resident MA	Hospital Inpatient MA	Community Resident MA	MA Waiver	FC MA FC-Non MA
Age	Any age	Any age	55 years of age or older	55 years of age or older	55 years of age or older Any age NH/Hospital
Services on or after	10/01/91	07/01/95	07/01/95	07/01/95	2/1/00
Recoverable Services	All MA benefits paid while residing in nursing home	All MA benefits paid while residing as an inpatient in a medical institution (hospital)	Home health skilled nursing Home health aide services Home health therapy and speech pathology Private duty nursing Personal care services (received on or after 4/1/00)	Home health skilled nursing Home health aide services Home health therapy and speech pathology Private duty nursing All waiver services Prescription/ legend drugs Benefits paid associated with an inpatient hospital stay Personal care services (received on or after 4/1/00)	CMO's actual costs of services as reported to DHFS, Prescription/ legend drugs Benefits paid associated with an inpatient hospital stay

Eff. 4/1/00: If the recipient meets all of the following:

1. Resides in a nursing home, or hospital.
2. Is required to contribute to the cost of care.
3. Is not reasonably expected to return home to live.
4. A lien is filed on their home.

All services listed above that were received on or after 4/1/00 may be recovered through the lien, except Family Care services which may be recovered as of 2/1/00.

This page last updated in Release Number : 02-03
Release Date: 07/01/02
Effective Date : 07/01/02

6.2 CORRECTIVE ACTION

6.2.1 Overpayments

An “overpayment” occurs when Medicaid (MA) benefits are paid for someone who was not eligible for them, or when MA payments are made in an incorrect amount. The amount of recovery may not exceed the amount of the MA benefits incorrectly provided. Some examples of how overpayments occur are:

1. Concealing or not reporting income or assets.
2. Failure to report a change in income or assets.
3. Providing misinformation, at the time of application, regarding any information that would affect eligibility.

6.2.1.1 Recoverable Overpayments

Initiate recovery for a MA overpayment if the incorrect payment resulted from one of the following:

1. **Client Error**
   Client error exists when an applicant, recipient, or any other person responsible for giving information on the client’s behalf, unintentionally misstates facts, which results in the client receiving a benefit that s/he is not entitled to or more benefits than s/he us entitled to. Client error occurs when there is a:

   a. Misstatement or omission of facts by a client, or any other person responsible for giving information on the client’s behalf, at a MA application or review.

   b. Failure on the part of the client, or any person responsible for giving information on the client’s behalf, to report changes in income or assets.

   A MA client is responsible for notifying his/her Economic Support (ES) worker of changes within 10 days of the occurrence.

   An overpayment occurs if the change would have adversely affected eligibility benefits or the post eligibility contribution amount (cost share, patient liability).

2. **Fraud**
   Fraud is also known as Intentional Program Violation (IPV).

   Fraud exists when an applicant, recipient, or any other person responsible for giving information on the client's behalf does any of the following:

1. Intentionally makes or causes to be made a false statement or representation of fact in an application for a benefit or payment.

2. Intentionally makes or causes to be made a false statement or representation of a fact for use in determining rights to benefits or payments.

3. Having knowledge of an event affecting initial or continued right to a benefit or payment and intentionally failing to disclose such event.

4. Having made application to receive a benefit or payment and intentionally uses any or all of the benefit or payment for something other than the intended use and benefit of such persons listed on the application.

If there is a suspicion that fraud has occurred, see 6.2.4 for information about referral to the District Attorney (DA).

3. **Client Loss of an Appeal**

Benefits a client receives due only to a fair hearing order can be recovered if the client loses the appeal.

A client may choose to continue to receive benefits pending an appeal decision. If the appeal decision is that the client was ineligible, the benefits received while awaiting the decision can be recovered. If an appeal results in an increased patient liability, cost share, or premium, recover the difference between the initial amount and the new amount.

6.2.1.2 Non-Recoverable Overpayments

Do not initiate recovery for a MA overpayment if it resulted from a non-client error, including the following situations:

1. The client reported the change timely, but you could not close the case or reduce the benefit due to the 10-day notice requirement.

2. Agency error (keying error, math error, failure to act on a reported change, etc).

3. Normal prospective budgeting projections based on best available information.

4. A change in the MA category if the benefits in the new category are the same as the original, and the post-eligibility contribution, if any, remains the same.

Example: Mom and child are on AFDC-MA. They concealed income which would have made the mom ineligible. The child would still have been eligible under Healthy Start. Only recover the incorrect payments made for the mom.

This page last updated in Release Number : 05-01
Release Date: 01/11/05
Effective Date: 01/11/05

6.2.2 Overpayment Calculation

6.2.2.1 Overpayment Period

If the overpayment is a result of a misstatement or omission of fact during an initial MA application, determine the period for which the benefits were determined incorrectly and determine the appropriate overpayment amount (6.2.2.2).

The ineligible period should begin with the application month.

For ineligible cases, if the overpayment is a result of failure to report a change, calculate the date the change should have been reported and which month the case would have closed or been adversely affected if the change had been reported timely.

For ineligible cases, if the overpayment was the result of fraud, determine the date the fraudulent act occurred. The period of ineligibility should begin the date the case would have closed or been adversely affected allowing for proper notice. If an overpayment exists, but the case is still being investigated for fraud, establish the claim so collection can begin promptly. Prosecution should not delay recovery of a claim.

6.2.2.2 Overpayment Amount

Use the simulation function in CARES to determine a client's eligibility, nursing home liability, premium or cost share (if applicable) based on the corrected information (CARES Guide Chapter VIII, 1.4.1). Use the actual income received by the client in determining if an overpayment has occurred.

To calculate the overpayment amount, use the RC (recipient claims) screen on MMIS. The overpayment amount depends on the MA category and whether the case is fee-for-service or enrolled in a HMO.

If the client would have been ineligible for the time period in question, recover the:

1. Amount paid for the medical services provided if the case is fee-for-service.

2. Managed care organization's capitation rate, less any contribution made by the client (ex. premium, cost share) if the case members are enrolled in a MA managed care organization. The capitation rate is the monthly amount MA pays to the client's managed care organization.

For the overpayment amounts for institutional (6.2.2.2.1), waiver (6.2.2.2.1), BadgerCare (6.2.2.2.3), Medicaid Purchase Plan (6.2.2.2.3), deductible (6.2.2.2.2) and Family Planning Waiver (FPW) 6.2.2.2.3.1 cases see the appropriate sections.

6.2.2.2.1 Increased Liability Cost Share

If a misstatement or omission of fact results in an increased nursing home liability or waivers cost share, the difference between the correct liability/cost share amount and the one the client originally paid is the overpayment amount.

Do not send a HCF 10110 (formerly DES 3070) to retroactively increase the patient liability on MMIS.

Family Care

For Family Care (FC) cases in which an omission of fact results in an increased Family Care liability or cost share, complete the following:

1. Recalculate the cost share or FC liability for any months that would have been affected.

2. Calculate the difference between the paid cost share or FC liability amount and the new cost share or FC liability amount.

3. Send the client a notice indicating the correct cost share for the months in question. Indicate on the notice the cost share amount still owed to the Care Management Organization (CMO) for each month in question. Do not attempt to recover the overpayment.

4. Report the new cost share amount to the CMO.

It is the CMO's responsibility to collect the difference between the cost share already paid and the correctly calculated cost share amount. This amount is not an overpayment of MA funds, but is the amount that the client owes the CMO directly.

6.2.2.2.2 Deductible

If a client error increases the deductible before the deductible is met, there is no overpayment. Recalculate eligibility and notify the client of the new deductible amount.

If the client met the incorrect deductible and MA paid for services after the deductible had been met, there is an overpayment. Recover the difference between the correct deductible amount and the previous deductible amount.

If the client was ineligible for the deductible, determine the overpayment amount. If the client prepaid his/her deductible, deduct any amount s/he paid toward the deductible from the overpayment amount.

6.2.2.2.3 Premiums

If a BadgerCare (BC) or Medicaid Purchase Plan (MAPP) case was still open for the timeframe in question, but there was an increase in the premium, recover the difference between the premium paid and the amount owed for each month in question. To determine the difference, determine the premium owed and view the premium amount paid on CARES screen AGPT.

BadgerCare

If the case was ineligible for BC, recover the amount of medical claims paid by the state and/or the capitation rate. Deduct any amount paid in premiums (for each month in which an overpayment occurred) from the overpayment amount (6.2.2.2).

MAPP

If the case was ineligible for MAPP, recover the amount of medical claims paid by the state. Deduct any amount s/he paid in premiums (for each month in which an overpayment occurred) from the overpayment amount.

6.2.2.2.3.1 Overpayments for Individuals Eligible for FPW Benefits

If an individual or case was ineligible for MA or BC but would have been eligible for FPW benefits, the calculation of the ultimate Medicaid overpayment amount is as follows:

1. If the incorrect/overpaid Medicaid benefits were “fee for service” medical claims paid by the state, recover the amount of benefits that were actually paid by the state minus any premiums which the client may have paid and the amount of any actual FPW services that were provided.

2. If the incorrect /overpaid Medicaid benefits were paid by an HMO, recover the HMO capitation rate paid by the state minus any premiums which the client may have paid and the “average” (currently $28.60) monthly cost of Medicaid FPW services.

6.2.2.2.4 Determining Liable Individual

Except for minors, collect overpayments from the MA client, even if the client has authorized a representative to complete the application or review for him/her.

> **Example:** Sofie applied for MA in December, and at that time designated her daughter, Lynn, as her authorized representative. Lynn did not report some of her mother's assets when she applied, which would have resulted in Sofie being ineligible for MA. Sofie was determined to be ineligible for MA from December through March. Recover from Sofie for any benefits that were provided to her from December through March.

If a minor received MA in error, make the claim against the minor's parent(s) or legally responsible relative if the parent or legally responsible relative was living with the minor at the time of the overpayment.

This page last updated in Release Number : 04-01
Release Date: 02/27/04
Effective Date: 02/27/04

6.2.3 Overpayment Process

Follow the instructions in Chapter VIII of the CARES Guide to enter the claim. CARES issues a repayment agreement the first business day of the month following the date the claim was entered. You are responsible to:

1. Enter the claim into CARES.
2. Send a manual Medicaid Overpayment Notice (HCF 10093) indicating the reason for the overpayment and the period of ineligibility.
3. Record the completed and signed repayment agreement on CARES screen BVPA within five days of receipt.
4. Record payments on CARES screen BVCP within five days of receipt.

CARES will:

1. Track the issuance of notices of non-payment and send automated dunning notices (i.e. past due notices).
2. Refer past due claims for further collection action (i.e. tax intercept) to the Central Recoveries Enhanced System (CRES).
3. Close the claim when the balance is paid.

6.2.3.1 Client Notice

Notify the client or the client's representative of the period of ineligibility, the reason for his/her ineligibility, the amounts incorrectly paid, and request arrangement of repayment within a specified period of time.

This page last updated in Release Number : 03-01
Release Date: 01/01/03
Effective Date: 01/01/03

6.2.4 Refer to District Attorney

See IMM Ch. I, Part E and Ch. II, Part D for referral criteria when fraud is suspected. The agency may refer the case to the state fraud investigation service provider where fraudulent activity by the client is suspected. If the investigation reveals a client may have committed fraud, refer the case to the district attorney or corporation counsel for investigation. The district attorney or corporation counsel may prosecute for fraud under civil liability statutes. The agency may seek recovery through an order for restitution by the court of jurisdiction in which the client or former client is being prosecuted for fraud.

This page last updated in Release Number: 03-01
Release Date: 01/01/03
Effective Date: 01/01/03

6.2.5 Fair Hearing

The ESA's decision concerning ineligibility and amounts owed may be appealed through a fair hearing. During the appeal process the agency may take no further recovery actions pending a decision.

This page last updated in Release Number: 03-01
Release Date: 01/01/03
Effective Date: 01/01/03

6.2.6 Agency Retention

The ESA can retain 15% of the payments recovered. See IMM Ch. II, Part A, 3.2.1 and Ch. II, Part D, 9.0.0.

This page last updated in Release Number: 03-01
Release Date: 01/01/03
Effective Date: 01/01/03

6.2.7 Restoration of Benefits

If it is determined that a client's benefits have been incorrectly denied or terminated, restore his/her MA from the date of the incorrect denial or termination through the time period that s/he would have remained eligible.

If the client was incorrectly denied or terminated for BC or MAPP with a premium obligation. Allow the client to pick which months s/he would like to receive benefits. Collect all premiums owed for all prior months before certifying the client for the months s/he chose.

If a client already paid for a MA covered service, inform the client that s/he will need to contact his/her provider to bill MA for services provided during that time.

A MA provider must refund the amount that MA will reimburse for the service. The provider may choose to refund up to the full amount billed to the client, but that decision is entirely optional.

This page last updated in Release Number: 03-01
Release Date: 01/01/03
Effective Date: 01/01/03

6.2.8 Incorrect Client Contribution

6.2.8.1 Premiums

If it is determined that a premium amount was incorrectly calculated for BC or MAPP and would result in a refund for the client, determine the correct premium amount for each month in which it was incorrect.

When reporting the refund to the BadgerCare or MAPP Unit, include the:

1. The client's Social Security Number.
2. Months for which a refund needs to be issued.
3. New premium amount.
4. Old premium amount.

Indicate whether there is a hardship situation that requires the refund to be processed more quickly.

6.2.8.1.1 BadgerCare

If the premium was recalculated and reduced for prior month(s), report the premium refund to the BadgerCare Unit by:

1. Telephone: 1 (888) 907-4455
2. Fax: (608) 251-1513

When submitting a fax, write "Attn: BC Premium Refunds".

6.2.8.1.2 Medicaid Purchase Plan (MAPP)

If the premium was recalculated and reduced for prior month(s), report the premium refund to the MAPP Unit by:

1. Telephone: 1 (888) 907-4455
2. Fax: (608) 251-8185

When submitting a fax, write "Attn: MAPP Premium Refund"

This page last updated in Release Number : 03-01
Release Date: 01/01/03
Effective Date: 01/01/03

6.3 THIRD PARTY LIABILITY

6.3.1 Introduction

Third Party Liability (TPL) means that another party, not MA or the client, is obliged to pay the bills for a MA recipient's medical services.

MA is the payor of last resort for the cost of medical care. All MA clients must sign over to the State of Wisconsin their rights to payments for medical services from third party payors (including health insurers, court ordered medical support payments and any other third party payor.) A client complies with this requirement by signing the application form.

At application the Economic Support Agency (ESA) must give a Notice of Assignment (DWSW-2477) to each client. If the client refuses to sign this form, the ESA must complete the lower portion of the form and file it in the case record. Do this no later than at the time of the interview. Give the client a copy of the notice. Do not delay processing a Medicaid application while waiting for the form to be signed. Do not penalize the client for not signing this form. File the original in the case record.

This page last updated in Release Number: 04-01
Release Date: 02/27/04
Effective Date: 02/27/04

6.3.2 HIPAA

HIPAA is the Health Insurance Portability and Accountability Act. A HIPAA Standard Plan is any group health care plan that provides medical care to covered individuals and/or their dependents directly or through insurance, reimbursement, or by some other means. Medical care means amounts paid for diagnosis, cure, mitigation (moderation), treatment or prevention of disease; or amounts paid for the purpose of affecting any structure or function of the body.

A policy that pays for a doctor's services in either an in-patient or outpatient setting qualifies as a HIPAA plan. The amount or type of benefits paid; co-insurance, deductibles, caps, etc., do not matter as long as the plan meets the HIPAA Standard Plan criteria.

The health care plan cannot be limited to a single type of covered service or only accessible in a very defined circumstance. Plans limited to accident, disability , vision, long term care or dental are **not** examples of HIPAA plans.

This page last updated in Release Number: 04-02
Release Date: 07/01/03
Effective Date: 07/01/03

6.3.3 REPORTING OTHER HEALTH INSURANCE

Collect insurance coverage information at application, Health Insurance review, person add, or when insurance changes and enter it into CARES. EDS will complete an insurance search and return verified insurance information through the CARES/ MMIS interface.

6.3.3.1 Casualty Claims

Casualty claims are those claims for MA benefits resulting from an accident for which a third party may be liable.

Example: Mike receives treatment for injuries suffered when he was hit by a car. The vehicle owner, the third party, may be responsible for reimbursing MA for those benefits.

The local Economic Support Agency (ESA) works with the Coordination of Benefits Unit to recover casualty claims.

The Coordination of Benefits Unit also recovers for MA recipients who are SSI recipients. Refer all SSI recipient casualty claims directly to the Coordination of Benefits Unit at:

Bureau of Health Care Systems and Operations
Coordination of Benefits Section
P.O. Box 309
Madison, WI 53701
Telephone: (608) 267-7282

6.3.3.2 Cooperation

The client must cooperate in providing TPL coverage and access information, unless s/he is exempt or there is good cause for refusing to cooperate.

If a caretaker refuses, without good cause, to provide health insurance information about a minor or dependent 18-year- old, the caretaker is ineligible until s/he cooperates.

Do not sanction the following for non-cooperation:

1. Minors, minor caretakers, and dependent 18-year-olds.
2. A caretaker requesting child support services for a child receiving SSI.
3. Pregnant woman – She may not be sanctioned during the pregnancy or for two months after the pregnancy has ended if the TPL source is the absent parent of her child(ren).

6.3.3.3 Good Cause Claim

When good cause is claimed (3.3.5), review the circumstances and decide on whether it is an appropriate claim of good cause. Make the appropriate entry on CARES screen AFMC regarding the good cause determination, and note the reason for the decision in case comments.

6.3.3.4 BadgerCare

Collect all insurance coverage and access information for BadgerCare (BC) clients and enter into CARES. EDS will complete an insurance search and return the insurance information through the CARES/MMIS interface.

See 5.7.3.4 for when a client is ineligible for BadgerCare when there is insurance coverage.

6.3.3.5 Nursing Home and Hospital Insurance

All clients must cooperate in providing Third Party Liability (TPL) coverage and access information (6.3.2) for nursing home and hospital insurance policies (5.8.6.3.1). All clients must:

1. Sign over to the State of Wisconsin all their rights to payments from hospital or nursing home insurance (6.3.3.5.1).

2. Turn over any payments to the State of Wisconsin (6.3.3.5.2) that s/he received from nursing home or hospital insurance while receiving MA.

   Any nursing home or hospital insurance payments that exceed the amount that MA has paid in benefits for that client will be refunded to him/her.

Terminate MA eligibility for the individual who is not cooperating in providing TPL insurance information (6.3.3.2), unless they have good cause (6.3.3.3).

6.3.3.5.1 Assignment

To assign hospital or nursing home insurance payments, the client must provide a statement in writing to the insurance company requesting that all future payments be made to the State of Wisconsin. Request a copy of the client's letter to the insurance company and send it to the following address:

Wisconsin Medicaid
TPL Unit
6406 Bridge Road
Madison, WI 53784-6220

The assignment includes all ongoing payments for as long as MA is received. Terminate MA eligibility for the individual that refuses to sign over these payments.

6.3.3.5.2 Recovery of Payments

In some cases, payments can only be signed over to the patient. The client must cooperate in turning over these payments to the State of Wisconsin, or his/her eligibility will end for not cooperating with providing TPL coverage and access information.

The client must write on the back of the check “Pay to the order of the State of Wisconsin” and sign the check.

Collect the payments monthly from the clients along with the corresponding Explanation of Benefits (EOB), and send them to the following address:

Wisconsin Medicaid
TPL Unit
6406 Bridge Road
Madison, WI 53784-6220

Close the case for non-cooperation with TPL requirements if the client refuses to turn over the payments.

This page last updated in Release Number: 02-04
Release Date: 10/01/02
Effective Date: 10/01/02

6.3.4 POLICIES NOT TO REPORT

Do not enter the following policies on AFMI or AFMC in CARES, or report them to EDS on the Health Insurance Information form (HCF 10115).

1. HMOs for which the State pays all or part of the premium.
2. Health Insurance Risk Sharing Plans (HIRSP).
3. Medicare (enter in CARES on AFMD).
4. General Assistance Medical Program (GAMP).
5. Indian Health Service (IHS). IHS is the exception to the rule that MA is the payor of last resort. For Native Americans who are MA clients, IHS is the payor of last resort. Do not enter these policies on CARES.
6. Policies that pay benefits only for treatment of accidental injury.
7. Policies that may be described as health insurance, but which pay only weekly or monthly based on the insured’s disability .
8. Limited insurance plans that pay only if there is a specific diagnosis, such as cancer policy. Report them only if the person insured has been diagnosed as having the disease s/he is insured against and if the benefits

are assignable.
9. Life Insurance.
10. Other insurance types that do not cover medical services

This page last updated in Release Number : 02-04
Release Date: 10/01/02
Effective Date: 10/01/02

6.3.5 INSURANCE THROUGH AN ABSENT PARENT

Dependents who are covered by an absent parent's HMO and reside in the HMO's service area must receive covered medical care from that HMO.

6.3.5.1 HMO Plans

Consider an HMO as unavailable if the dependent does not live in the area of the HMO or if they are unable to travel to it for their medical care. Consider them as uninsured until the Child Support Agency (CSA) can have them changed to a non-HMO plan. Complete the Health Insurance Information form (HCF 10115) and give it to the CSA. Write on it in red "NOT ENTERED IN CARES – DISTANT HMO."

For the purpose of determining BC eligibility, consider this access to insurance.

6.3.5.2 Referral to CSA

Refer the absent parents of all clients, whether or not paternity has been established, to the CSA.

If the custodial parent is able to provide all the necessary health insurance information, enter that information into CARES. If s/he can only provide partial or no information, the CSA will contact the absent parent and obtain the needed information.

This page last updated in Release Number: 02-04
Release Date: 10/01/02
Effective Date: 10/01/02

6.3.6 HEALTH INSURANCE RISK SHARING PLAN

The Health Insurance Risk Sharing Plan (HIRSP) is available for purchase by Wisconsin residents under age 65 who are not able to find adequate health insurance coverage in the private sector.

Advise MA clients who are covered by HIRSP that they must let Blue Cross/Blue Shield know immediately when they begin MA eligibility. To do this, contact:

Plan Administrator
Wisconsin Health Insurance Risk
Sharing Plan

6406 Bridge Road, Suite 18
Madison, WI 53784-0018

Telephone: 1-800-828-4777 or (608) 221-4551

This page last updated in Release Number: 02-04
Release Date:10/01/02
Effective Date: 10/01/02

6.3.7 HEALTH INSURANCE PREMIUM PAYMENT (HIPP)

HIPP pays the employee's portion of the employer subsidized health care coverage. EDS determines if it is more cost effective to buy the employer's insurance or enroll them in BC or MAPP.

6.3.7.1 Cost Effective

To assess cost effectiveness, EDS checks:

1. If the employer pays 60-80% of the premium cost, **and**
2. For BC, that no one has been enrolled in the past six months in a HIPAA plan in which the policy owner is an AG member.

If these two criteria are met, then EDS looks at projected costs of the insurance premiums, co-insurance and deductibles. Those costs are then compared to the projected expense of paying for medical services directly through MA.

If it is cost-effective to buy the employer-subsidized insurance, the HIPP Unit will notify those clients who are required to enroll in an employer's health plan and provide additional information related to enrollment, coverage, and cooperation.

HIPP may pay the premium for a non-MA family member if that member needs to enroll in the group health plan in order to obtain coverage for the MA client. MA will only pay for the premiums of the ineligible family member(s) and not any of their other cost sharing expenses (e.g. prescription co-pays). MA will continue to cover the employer's health insurance premium, deductibles and co-insurance for the MA client.

6.3.7.2 Participation in HIPP

Clients participating in HIPP will have MA as a backup. If the employer's health insurance does not cover something that MA does, then MA will pick up the payment.

6.3.7.3 Cooperation

To remain eligible for BC or MAPP, the adult whose employer can provide insurance must:

1. Cooperate in providing information necessary to assess cost-effectiveness, **and**

2. Agree to enroll and actually enroll in the employer's health care plan if the plan is determined to be cost-effective.

Failure to cooperate or enroll in the employer's plan is non-cooperation. The adult who could get insurance coverage is not eligible for BC or MAPP. If one adult fails to cooperate, it does not affect the spouse or children's MA eligibility.

The EDS HIPP unit worker will communicate HIPP non-cooperation directly to you. Enter the non-cooperation and the ineligible adult will close after the next adverse action.

6.3.7.4 Exceptions

Listed below are two exceptions to participating in HIPP:

1. Clients who are enrolled in a Special Managed Care Program (SMCP).

   Some examples of SMCP's are Independent Care Program, Elder Care Option Program, and Wraparound Milwaukee. Do not consider the client non-cooperative if s/he refuses to participate in HIPP while enrolled in a SMCP. The HIPP Unit will monitor the client's enrollment in SMCP's to determine the client's responsibility for HIPP participation.

2. A client who is unable to enroll in an employer's health plan on their own behalf.

   An example of this situation would be when a MAPP client's spouse is unwilling to enroll the client in their employer based health plan. Since the client's spouse has the cost-effective employer's health plan, but chooses not to enroll the MAPP client, the coverage under that plan is considered unavailable to the client.

6.3.7.5 Not Cost Effective

If it is not cost-effective to buy the employer-subsidized insurance, the client will remain eligible for MAPP or BC.

6.3.7.6 BadgerCare HMO Enrollment

If it is not cost-effective to buy the employer-subsidized HMO Enrollment insurance, EDS enrolls family members into a BadgerCare HMO. If only one HMO in an area accepts BC clients, s/he can choose to remain fee-for-service. If you indicate that the AG has access to insurance in CARES, EDS will not enroll them in a HMO until the HIPP test is completed.

6.3.8 TPL END DATE

Each month EDS sends a Third Party Liability (TPL) Segment – End Date Report to all certifying agencies (6.3.11). The report lists cases that have an insurance end date that has been applied in the last month.

If EDS verifies a major medical policy has ended, EDS automatically updates CARES and sends an alert. The worker should:

1. Ask the client if the insurance has ended.

2. If the client says that the insurance listed has not ended, the information is considered questionable. Verify the insurance information and update CARES (AFMC and AFMI).

3. Run eligibility.

The information on the End Date Report is arranged in eight columns under the following numbers:

1. Name of the casehead.
2. Name of the insured person.
3. Insured person's MA ID number.
4. Name of the insurance policy holder.
5. Policy number. The name of the insurance carrier appears under the policy number.
6. The date on which coverage with the carrier named in #5 ended.
7. Who submitted the end date? If "INS CO" is listed, the insurance carrier provided the end date. If "AGENCY" is listed, the ESA or CSA provided the end date.
8. Indicates whether the person named in #2 has another insurance policy that is still in effect.

   If the open insurance policy (indicated in #8) is a drug or dental plan that was part of the terminated policy, it must also be ended.

When a TPL Segment ends, EDS allows medical bills that would have gone first to an insurance company to be reviewed immediately by MA for payment.

6.3.9 DOUBLE PAYMENT

Sometimes EDS finds that services have been paid for by both MA and a third party that is not listed in the MA file. When this happens, the worker may receive a Coverage Discrepancy Report from EDS.

If you receive this notice, review your files and contact the client to find out the TPL status of the MA group members. If you find there is private health insurance available to any of the members, update CARES.

This page last updated in Release Number: 02-04
Release Date: 10/01/02
Effective Date: 10/01/02

6.3.10 HEALTH INSURANCE INFORMATION FORM

If CARES is not available, the Health Insurance Information Form (HCF 10115) can be used to collect insurance information. Complete a separate form for each insurance policy if a person has more than one. Listed below are some instructions for filling out this form.

IM/CS Blocks. If you can complete the form in its entirety, check IM. Do not check this box if you refer the form to Child Support for completion.

Added. Check the "Added" box when the policy in question has never been sent to EDS, and is not on their file. Complete the entire form.

Changed or Ended. Check the "Changed or Ended" box when altering information that is already on EDS's file and complete these items:

1. The shaded area on the top.
2. MA ID numbers and names of only those case members affected by the change. Date of birth is required. Relationship is not.
3. The insurance company name in Box 1.
4. The policy number in Box 6.
5. The policy start date in Box 9.
6. The information you want to change. For example, to report the date on which coverage terminated, enter the end date in Box 10.

Deleted. Check the "Deleted" box when removing insurance information. Do not use a delete transaction in place of a change transaction when valid insurance coverage ends. Use it only if:

1. The insurance data put on the file was not valid during a period of MA eligibility, **or**

2. The information should never have been put on the file because, for

instance, it is life insurance.

To change the policy number, the insurance company billing address, or the start date of coverage, send EDS:

1. A (HCF 10115) marked "Delete" (on which you have deleted the incorrect information), **and**

2. A second (HCF 10115) marked "Add" (on which you have added the correct information).

Staple the forms together. Mark on the delete copy in red "1 of 2". Mark on the add copy in red "2 of 2".

When you are submitting a delete form with an add form, complete the add form in its entirety.

For the delete transaction, complete the shaded area on the top.

6.3.10.1 Section A

In Section A, list the MA ID numbers and the names of only those case members affected by the delete and their date of birth.

1. Enter the insurance company name in Box 1.
2. Enter the policy number in Box 6.
3. Enter the policy start date in Box 9.

6.3.10.2 Section B

Policy Number. If the insurance ID card contains nothing but a group number, put the insured person's Social Security Number (SSN) in this space.

Policy Start Date. Use the effective date of the policy listed on the insurance ID card. If the date is not available, make the start date equal to or earlier than the start date of eligibility.

6.3.10.3 Section C

The policyholder’s SSN is voluntary. Failure to provide your SSN may result in a processing delay.

6.3.10.4 Section D

If a retired client has insurance through a former employer, list that former employer and the address, if available.

6.3.10.5 Where to Send

Send the original to:

EDS - TPL Unit
P.O. Box 7636
Madison, WI 53707-7636

This page last updated in Release Number : 02-04
Release Date : 10/01/02
Effective Date: 10/01/02

6.3.11 TPL Segment End Date Report Sample

THIRD PARTY LIABILITY SUBSYSTEM

* *

TITLE:	HMKR559Q - TPL Segment End Date Report
FREQUENCY/MEDIA:	Monthly/paper
FICHE HEADER:	n/a
JOB NAME:	
OBJECTIVE:	The purpose of this report is to identify recipients that have had an end date applied to the TPL segment the previous month. the report is used by certifying agencies and child support as an aid to identify additional insurance coverage, or ensure child support enforcement when insurance coverage is court ordered. One copy of the report is produced and distributed by EDS to certifying and child support agencies.
ORGANIZATION:	Sorted in ascending order by agency code, by absent parent code, by worker number, and then by case head name.
EXCLUSIONS/LIMITATIONS:	Recipients having an end date changed in the last month, but currently not eligible for Medical Assistance are excluded. TPL segments which were deleted from the eligibility file are excluded. TPL segments end dated due to T and E link are also excluded. All other T-Segments having end dates applied during the current month are included.

FIELD DESCRIPTIONS:	
ABSENT PARENT:	Identifies the policyholder as a parent who is absent from the home. Absent parent code is converted as follows: 1 – yes 0 – no
COUNTY:	Three-digit numeric code identifying the certifying agency and, in most cases, the county in which the agency is located. Descriptions of certifying agency codes can be found in Quick Reference.
AGENCY (AGC):	Two-digit numeric code identifying the specific W2 or non-W2 agency within a county. Description of agencies can be found in Quick Reference.
IM WORKER:	Six-digit agency worker number from the recipient's B-segment.
CARES CASE:	10-digit identifier assigned by CARES to a group of CARES eligible recipients.
ORG	TPL origin code. One-byte. Identifies the system by which TPL was established. Valid values are C (CARES), K (KIDS), and M (MMIS).
INSTRUCTIONAL MESSAGE	A message informing each agency how to use the report.
CASE HEAD LAST FIRST	Casehead's last and first name (e.g., parent of a child).
RECIPIENT LAST FIRST	Name of individual receiving Medical Assistance services.
MA NUMBER	Recipient's 10-digit Medical Assistance identification number.
POLICY HOLDER LAST FIRST	Insured's last and first name from the end dated TPL segment.
POLICY NUMBER	Policy number for the end dated TPL segment.
ENDED POLICY	Name of the insurance carrier from the end dated TPL segment.
END DATE	Date the insurance ended from the TPL segment.
SOURCE	Written description of the source of update information as identified by the source code on the end dated TPL segment. The source codes are converted as follows: 1 – DHCF 2 - Insurance Company

	3 – Unknown 4 - Child Support Agency 5 – Agency 6 – HIPP 7 – Insurance Disclosure
SECOND TPL SEGMENT	If a TPL segment on the recipient's file still exists with an open end date, the name of the insurance carrier is printed.

This page last updated in Release Number: 02-04
Release Date: 10/01/02
Effective Date: 10/01/02

7 BENEFITS

7.1 BENEFITS

7.1.1 BENEFITS

7.1.1.1 Benefit Introduction

MA covers many health care services. However, limitations apply that ensure only medically necessary services are provided.

This page last updated in Release Number: 03/02
Release Date: 04/01/03
Effective Date: 04/01/03

7.1.2 Full-Benefit MA

Those subprograms of MA that are eligible to receive full- benefit MA services include:

1. Katie Beckett Medicaid (5.11.6).
2. Community Waivers Medicaid (5.9).
3. Institutions Medicaid (5.8).
4. AFDC-Medicaid (cat needy).
5. Medicaid Extension (earnings/hours/loss of disregard) (5.6).
6. AFDC-Related Medicaid (cat or med needy).
7. EBD Medicaid (cat or med needy).
8. Continuously Eligible Newborn (CEN) Medicaid (5.2.5).
9. Healthy Start for Kids (6-18 years of age) (5.2.6.4)
10. Healthy Start for Children Under 6 (cat or med needy) (5.2.6.3)
11. Healthy Start for Pregnant Women (5.2.6.1).
12. 60-Day End-Pregnancy Extension (5.6.5)
13. Foster Care Medicaid (5.3.)
14. Adoption Assistance Medicaid
15. Medicaid Met Deductibles (4.9.8)
16. Medicaid Purchases Plan (MAPP) (5.12)
17. BadgerCare (5.7)
18. Wisconsin Well Woman Medicaid (5.17)

This page last updated in Release Number : 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

7.1.3 LIMITED BENEFIT MA

Limited benefit subprograms of MA includes:

1. Medicare Buy-In Programs (5.14).
2. Emergency Services for Non-Qualifying Aliens (3.2.3).
3. Tuberculosis-Related MA (5.11.7).
4. Presumptively Eligible Pregnant Women (5.2.4).
5. Family Care Non-MA (5.13.3).
6. SeniorCare (5.16)
7. Family Planning Waiver (5.15)

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

7.1.4 COVERED SERVICES

A covered service is any medical service that MA will pay for an eligible client, if billed. The Division of Health Care Financing (DHCF) certifies qualified health care providers and reimburses them for providing MA covered services to eligible MA clients. Clients may receive MA services only from certified providers, except in medical emergencies. MA reimburses emergency medical services necessary to prevent the death or serious impairment of the health of a client even when provided by a non-certified provider.

MA providers must submit a prior authorization request to the Medicaid fiscal agent before providing certain MA services.

Examples of MA covered services include:

1. Case management services.
2. Chiropractic services.
3. Dental services.
4. Family planning services and supplies.
5. Federally Qualified Health Center (FQHC) services.
6. HealthCheck (Early and Periodic Screening, Diagnosis and Treatment – ESPDT) of people under 21 years of age.
7. Home and community-based services authorized under a waiver.
8. Home health services or nursing services if a home health agency is unavailable.
9. Hospice care.
10. Inpatient hospital services other than services in an institution for mental disease.
11. Inpatient hospital, skilled nursing facility, and intermediate care facility services for patients in institutions for mental disease who are:

a. under 21 years of age.
b. under 22 years of age and received services immediately before reaching age 21.
c. 65 years of age or older.

12. Intermediate care facility services, other than services at an institution for mental disease.
13. Laboratory and X-ray services.
14. Legend drugs and over-the counter drugs listed in Wisconsin Medicaid's drug index.
15. Medical supplies and equipment.
16. Mental health and medical day treatment.
17. Mental health and psychosocial rehabilitative services, including case management services provided by the staff of a certified community support program.
18. Nurse midwife services.
19. Nursing services, including services performed by a nurse practitioner.
20. Optometric or optical services, including eyeglasses.
21. Outpatient hospital services.
22. Personal care services.
23. Physical and occupational therapy.
24. Physician services.
25. Podiatry services.
26. Prenatal care coordination for women with high-risk pregnancies.
27. Respiratory care services for ventilator-dependent individuals.
28. Rural health clinic services.
29. Skilled nursing home services other than in an institution for mental disease.
30. Speech, hearing, and language disorder services.
31. Substance abuse (alcohol and other abuse services).
32. TB (tuberculosis) services.
33. Transportation to obtain medical care.

If you or the client have additional questions, contact Recipient Services at 1-800-362-3002.

7.1.4.1 Transportation

Federal regulations require that MA programs provide transportation to clients who need to obtain MA services. Transportation by ambulance, specialized medical vehicle (SMV) or ESA approved common carrier is a covered MA service when provided in accordance with the appropriate sections below.

7.1.4.1.1 Ambulance

Ambulance transportation is a covered service if it is provided by a MA certified ambulance provider, and the client is suffering from an illness or injury that rules out other forms of transportation, and only if it is for:

1. Emergency care when immediate medical treatment or examination is needed to deal with or guard against a worsening of the person's condition.

2. Non-emergency care when authorized in writing by a physician, physician assistant, nurse midwife or nurse practitioner.

ES is not responsible for prior authorization for ambulance services.

7.1.4.1.2 Specialized Medical A Specialized Medical Vehicle (SMV)

A Specialized Medical Vehicle (SMV) is a vehicle equipped with a lift or ramp for loading wheelchairs. The driver of a SMV must have first aid training and CPR certification.

SMV transportation is a covered service if the person is legally blind, or indefinitely or temporarily disabled as documented in writing by a physician, physician assistant, nurse midwife, or nurse practitioner. The documentation from the provider must indicate why the person's condition prevents him/her from using a common carrier or private vehicle. In the case of a temporary disability , the documentation must indicate the expected length of time SMV services will be necessary, as well as why the person cannot use common carrier transportation.

SMV services are available only for transportation to a MA covered service (including community waiver services if transportation is included in the per diem). A client's age, place of residence, lack of parental supervision, or lack of a driver's license are not qualifying criteria for SMV services.

ES is not responsible for prior authorization for SMV services, but may refer a client who is unable to use common carrier to a MA certified SMV provider.

Managed Care

MA HMOs and special managed care programs authorize and reimburse transportation providers for ambulance and specialized medical vehicle services. Care Management Organizations (CMOs) do not cover common carrier or ambulance service, but do contract for SMV services. If a client is not in a HMO, s/he can call 1-800-362-3002 with questions on ambulance or SMV providers.

7.1.4.1.3 Common Carrier

Common carrier means any mode of transportation approved by an Economic Support Agency (ESA), except an ambulance or a SMV. Common carrier transportation is a covered service if the ESA (or a designated agency) authorizes the transportation.

Transportation to Out-of-State Providers

Except for services provided by MA-certified "border-status" providers, all non-emergency out-of-state services require prior authorization from the MA program. According to s. HFS 101.03, a border-status provider is, “a provider located outside of Wisconsin who regularly gives service to Wisconsin recipients and who is certified to participate in MA.”

If the MA program approves a request for out-of-state health care services, the transportation to receive the service may be covered if authorized by the ESA. The ESA may approve a request for the transportation only if prior authorization has been granted for the health care service that the recipient will be receiving from the out-of-state provider. The ESA should not approve requests for out-of-state transportation if the MA program has not authorized the out-of-state health care service.

As with other travel, approve the least expensive means of transportation, which the client can use, and which is reasonably available when the service is required. The ESA may provide reimbursement up to the charges of the common carrier, for mileage expenses or a contracted amount the ESA or its designated agency has agreed to pay the transportation provider. Related travel expenses may be covered as described below. The ESA may request verification of expenses, or documentation that the trip occurred.

Transportation Administration
When providing common carrier transportation, the ESA should use the most cost-effective mode of transportation possible. The ESA reimburses transportation by common carrier. Clients may contact the ESA with questions on common carrier reimbursement.

Common carrier transportation requires authorization by the county/tribal agency prior to departure. The client or someone acting on his/her behalf may request the authorization. The request can be made by phone, in person, or in writing to the ESA. Denials must be in writing and must explain why the request was denied. The county/tribal agency may delegate common carrier authorization to another county/tribal, or other local agency, provided clients are assured of transportation to MA covered services.

Issue authorizations and denials with reasonable promptness. For authorizations, specify the means of transportation authorized. If recurring medical care is needed, you may authorize all of the trips needed for a specific time period.

Reimbursement
Follow these guidelines when approving or reimbursing transportation services:

1. Approve the least expensive means of transportation, which the client can use, and which is reasonably available when the service is required. If neighbors, friends, relatives or voluntary organizations have routinely

provided transportation at no cost, the county or tribal agency does not have to approve that transportation.

2. Do not restrict approval according to the type of covered service. For example, you may not limit reimbursement for transportation to only urgent medical services or physician provided services.

3. Reimburse transportation only to and from a location where the client receives a MA covered service.

The ESA may request documentation that a MA covered service was provided:

a. If provision of covered services is questionable or

b. The client was unable to obtain prior approval.

4. The county/tribal agency may limit reimbursement for mileage to the nearest provider if the client has reasonable access to health care of adequate quality from that provider.

Example: There is a pharmacy 11 miles from the client's home that could have filled his/her prescription. But s/he went to one 32 miles from home. Reimburse him/her on the basis of the shorter distance. The county or tribal agency may require provider documentation of the need for a specialized service at the location requested.

5. The ESA may reimburse clients who use their own vehicle up to $0.24 a mile, and may bill up to $0.26 a mile and keep up to $0.02 a mile for administration.

If the vehicle is lift/ramp equipped, you may reimburse up to $0.50 a mile. The ESA may bill $0.52 a mile and keep up to $0.02 a mile for administration.

6. A volunteer driver (someone who provides service to another person) may be reimbursed up to $0.33 a mile. If they carry more than one client on a single trip, volunteer drivers may be reimbursed up to $0.35 a mile. The county or tribal agency may bill up to $0.36 a mile ($0.38 for more than one client on a single trip) and keep up to $0.03 a mile for administration.

7. You may reimburse public carriers, such as taxis and buses for non-contracted trips, up to their usual and customary charges to the general public. Reimburse the provider directly, or have the client pay for the transportation and reimburse him/her.

8. When no alternative transportation arrangements are available or when it is the most cost effective alternative, the ESA may contract with SMVs or Human Service Vehicles (HSVs).

   Limit reimbursement to no more than $1.05 per loaded mile for each client. Loaded mileage is the mileage driven when the client is on board.

   When an agency contracts with a SMV, HSV, taxi company or similar entity, the agency may charge administrative costs of up to five percent of the amount paid. The amount paid must not exceed $1.05 per loaded mile for each client.

9. County or tribal agencies may operate their own program to transport clients. They may claim reimbursement as follows:

   a. Car. Up to the rate per mile allowed for state employees who use their own car, and keep up to 3 cents per mile for administration.

   b. Van. Up to $.0.50 per mile and keep up to $0.05 per mile for administration. If the agency hires a driver for transporting clients exclusively, it may claim up to $1.05 per mile. Do not claim additional amounts for the driver's salary or for administrative expenses.
      For the most current state rates, refer to http://www.dhfs.state.wi.us/bfs/pdf/APP/Travel/trav10.pdf. The information in this page should be updated annually.

10. The county or tribal agency may not use common carrier transportation funds to pay drivers while they are not actively providing direct transportation services. Do not claim reimbursement for the cost of purchasing the vehicle.

11. The county or tribal agency may cover travel-related expenses if the travel is "other than routine." Travel that is other than routine may be defined as trips that are significantly beyond the distances typically traveled to obtain health care services in a particular locality.

    Related travel expenses may also include the cost of meals and commercial lodging en route to and from, and while receiving, a MA-covered service. Related travel expenses may also include the cost of an attendant to accompany the client if, the client's age and/or physical condition warrants an attendant. If the client is age 16 years or older, the need for an attendant must be determined and documented in writing by a physician, physician assistant, nurse midwife, or nurse practitioner.

    Only reimburse the cost of one attendant, unless the physician, physician assistant, nurse midwife, or nurse practitioner documents in writing, that the recipient's condition requires the physical presence of more than one attendant. The ESA or its designated agency must maintain the statement of need.

12. An attendant is a person, in addition to the driver, that is specifically trained in procedures that are necessary for care and transportation of the client. An attendant's costs may include transportation, lodging, meals, and a salary.

    When the attendant is a member of the client's family, limit reimbursable costs to transportation, commercial lodging and meals. A client's family consists of the client, his/her spouse, parent, stepparent, foster parent, half-siblings, the client's natural, adoptive, and stepchildren, grandparent, and grandchildren.

    County/tribal agencies may approve up to four weeks of expenses without DHFS approval. A request for attendant care over four weeks requires prior authorization by DHFS. Send prior authorization requests to:

    Transportation Policy Analyst
    Division of Health Care Financing
    P.O. Box 309
    Madison, WI 53701-0309

    Reimbursement for the client's and/or attendant's meals and lodging must be no greater than the amounts paid by the state to its employees for those expenses. Reimburse multiple night stays at state rates for employees. The minimum salary for an attendant must be the minimum federal hourly wage. For the most current state rates, refer to http://www.dhfs.state.wi.us/bfs/pdf/APP/Travel/trav10.pdf. The information in this page should be updated annually.

13. The county/tribal agency may establish their own procedures for cash advances to clients.

14. Apply these reimbursement guidelines for clients who are retroactively certified for MA. They are entitled to request reimbursement of medical transportation costs that occurred during the retroactive period.

15. Medicare beneficiaries who are ineligible for MA are not eligible for MA transportation reimbursement.

16. For common carrier transportation, MA will reimburse ESA's for transportation costs that have prior authorization. The ESA may also work with an HMO to coordinate the common carrier transportation.

MA encourages ESA's that choose not to contract with an HMO for transportation to work with the HMO so that the enrollee's transportation needs can be met.

Transportation Waiver

When you deny a request for transportation expenses, tell the client that s/he can ask for a waiver. If s/he asks for a waiver, write up the waiver request.

In your waiver request

1. Refer to the Administrative Rule permitting waivers (HFS 106.13).

2. If the denial is for a family member's attendant services, note the waiver request is to waive Administrative Rule HFS 107.23 (3).

3. Describe the specific case situation.

4. Give your reason(s) for requesting the waiver. An example of a reason would be that enforcement of the requirement would result in unreasonable hardship for the person.

5. Sign the request and send it to:

   Transportation Policy Analyst
   Division of Health Care Financing
   P.O. Box 309
   Madison, WI 53701-0309

This page last updated in Release Number : 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

7.1.5 CO-PAYMENT

Clients are responsible for making a co-payment for many medical services and procedures. Children less than 18 years of age, nursing home residents and people in state-contracted or other MA managed care programs receiving managed care covered services are exempt from co-payments.

Medical services exempt from co-payments are:

1. Emergency hospital and ambulance services and emergency services related to the relief of dental pain.

2. Services related to pregnancy.

3. Family planning services and supplies.

4. Common carrier transportation, if provided through or paid for by a county/tribal human or social services department.

5. Home health services.

6. Personal care services.

7. Case management services.

8. Outpatient psychotherapy services received that exceed 15 hours or $500, whichever occurs first, during one calendar year.

9. Occupational, physical, or speech therapy services received that exceed 30 hours or $1,500 for any one therapy, whichever occurs first, during one calendar year.

10. Hospice care services.

11. Substance abuse (alcohol and other drug abuse) day treatment services.

12. Respiratory care for ventilator-assisted clients.

13. Community Support Program (CSP) services.

Providers are required to make a reasonable effort to collect the co-payment. Co-payments range from $0.50 to $3.00 for each procedure or service. Providers may not refuse services to a client who fails to make a co-payment.

This page last updated in Release Number : 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

7.1.6 HMO ENROLLMENT

Most MA clients who are eligible for Family MA and reside in a MA HMO service area must enroll in a HMO.

Clients may choose their own HMO or work with the HMO Enrollment Specialist to choose the best one for their needs. They may choose at any time during the enrollment process. All eligible members of the client's family must choose the same HMO. However, individuals within a family may be eligible for exemption from enrollment.

This is the enrollment process:

1. Clients residing in a HMO service area receive a HMO enrollment packet. The packet has an enrollment form, a list of available HMOs, instructions on how to choose a HMO and how to find out if a provider is affiliated with a HMO.

2. If the client does not choose a HMO within two weeks of receiving the enrollment packet, s/he receives a reminder card. Clients in areas with only one available HMO will stop here in the process. They do not have to enroll in a HMO.

3. If the client has not chosen a HMO after four weeks, and lives in an area covered by two or more HMO's, s/he will be assigned a HMO. A letter explaining the assignment will be sent to him/her. S/he will receive another enrollment form and have an opportunity to change the assigned HMO.

4. S/he will then receive a notice confirming enrollment in the assigned or chosen HMO for the following month. The client has up to three months to change HMOs, once enrolled. This is the open enrollment period. After the initial three months, the client is locked into the HMO and cannot change for nine months. If your client has questions about HMO enrollment, s/he should contact the Enrollment Specialist at 1-800-291-2002.

Exemptions: A client may qualify for an exemption from HMO enrollment if they meet certain criteria, such as a chronic illness, high-risk third trimester pregnancy, or continuity of care concerns, etc.

If the client believes s/he has a valid reason for exemption, s/he should call the HMO Enrollment Specialist at 1-800-291-2002. The number is also in the enrollment materials they receive.

7.1.6.1 Change of Circumstances

Clients who lose MA eligibility, but become eligible again may be automatically re-enrolled in their previous HMO.

If the client's eligibility is re-established after the six-month period, s/he will be automatically re-enrolled in the previous HMO, unless the HMO is no longer accepting reassignments.

After six months, or if the HMO is no longer accepting reassignments or has exceeded its enrollment level, s/he will receive an enrollment packet, and the enrollment process will start over.

7.1.6.2 Disenrollment

Clients are automatically disenrolled from the HMO program if:

1. Their medical status code changes to a non-Family MA subprogram.
2. They become eligible for Medicare.
3. They lose eligibility.
4. They move out of the HMO's service area.

Clients who move out of the HMO service area receive a new packet showing the HMO(s) available in the new area and the enrollment process begins again. If no HMO covers the client's new area, s/he remains fee-for-service.

7.1.6.3 EDS Ombuds

Clients with questions about their rights as HMO enrollees may call 1-800-760-0001 or write:

HMO Ombuds
P.O. Box 6470
Madison, WI 53791-9823

This page last updated in Release Number : 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

7.1.7 MEDICAID CARDS

Forward cards are issued to MA clients. These cards are blue, permanent, plastic, and display the word "Forward" on them. Clients use the same Forward card each month. Monthly cards are not issued.

Each person in the family who is eligible for MA receives his/her own card. The cards do not display eligibility dates. All MA services are paid for under the MA ID number on the card. For newborns that do not have a MA ID, MA pays for all services within the first ten days of the baby's birth under the mother's MA ID number. The baby need not be determined eligible for the claims to be paid. If the baby has a MA ID, services are billed under that number. If the baby does not have a MA ID, CARES will assign a pseudo ID number. EDS assigns a pseudo ID if the newborn is reported to them by a MA HMO or hospital, and the newborn has not yet received an SSN.

Clients will know if they are eligible based on positive and negative notices sent from the ESA. Clients who receive a notice that they are no longer eligible for

MA should keep their Forward cards. Cards should not be thrown away. If a client becomes eligible again, they will use the same Forward card originally issued. If they have questions regarding their eligibility status, they can call you or Recipient Services at 1-800-362-3002.

7.1.7.1 Appeals

Keep an MA case in appeal status open if the client makes a request prior to the closure date. The client can continue to use their Forward card until a decision is made regarding his/her eligibility.

7.1.7.2 Homeless

Make ID cards available to homeless MA clients who have no fixed address or mailing address. Use your agency address or some other fixed address for delivery.

7.1.7.3 Lock-in Program

A program called 'Lock-in' is available in cases of benefit misuse. The client is assigned to a particular provider for services. When a client receives health care, the providers are told of the client's restriction(s) when verifying eligibility. If you have information that your client may be misusing benefits or his/her Forward card, send the client's name, address, card number, and a summary of the facts and any documentation to:

Division of Health Care Financing
Bureau of Health Care Program Integrity
P.O. Box 309
Madison, WI 53701-0309

Or call providers services at (800) 947-9627 or (608)221-9883 .

7.1.7.4 Temporary Cards

The following cards are the only paper MA cards:

1. Green Cards
2. Tan Cards

7.1.7.4.1 Green Cards

EDS does not issue temporary cards. The Economic Support Agency (ESA) issues them. Each agency must issue a temporary card if the client does not already have a Forward card and needs health care within the two to three days before s/he receives one in the mail. The green temporary card is the only way the client may be able to receive services without having to pay out-of-pocket, since eligibility is not on MMIS yet for the provider to verify.

Order the green temporary MA ID card stock from:

Medicaid Eligibility Maintenance
P.O. Box 7636
Madison, WI 53707-7636
Phone: (608) 221-4746
Fax: (608) 221-0885

When ordering, indicate the agency, contact person, and number of blank cards desired.

Include the following on each temporary ID card you issue:

1. MA ID number.
2. Agency code.
3. Medical status code.
4. Client's full name.
5. Client's date of birth.
6. Client's sex (M or F).
7. Client's address.
8. Valid dates: Do not use future dates beyond the current benefit month.
9. Other insurance coverage. If private insurance, include the name. If Medicare, include the Medicare number as it appears on the client's Medicare card with "A" for Part A and/or "B" for Part B.

Do not issue a temporary card to clients who would not normally receive a Forward card. Clients in the following categories do not get a Forward card, so should not be issued temporary cards:

1. AE – Alien Emergency services. No card is necessary because only services directly related to the emergency are reimbursable by MA.

2. FC - Family Care Non-MA. MA does not cover services provided to clients in this category. If the client is enrolled in a Family Care CMO, limited services are provided entirely by that CMO.

3. Medicare Premium Assistance Programs

a. SB – SLMB only
b. SLMB+ – Qualified individual, group 1
c. ALMB – Qualified individual, group 2
d. QW – QDWI

MA pays for these clients' Part A and/or Part B Medicare premiums. No health care services are payable by MA.

7.1.7.4.2 Tan Cards

Temporary tan cards are provided to the client from the PE provider after having completed a presumptive eligibility application and the provider has found the client eligible for PE. The provider sends the completed PE application to EDS. Once EDS receives the PE application from the provider and applies the PE eligibility to MMIS, a Forward card is sent to the client.

7.1.7.5 Lost/Stolen Cards

If a client needs a replacement card, s/he or an authorized representative, including ES, should call Recipient Services at 1-800-362-3002. A new Forward card will be issued and will be sent out the following business day. The 16-digit number on the card is unique to each card. If a new card is issued, it will have a new card number to help prevent fraud and monitor card stock.

Replacement cards are issued automatically when:

1. The client's name changes.
2. The card was returned as undeliverable and the client's address changes.

A replacement for any other reason must be requested through Recipient Services, 1-800-362-3002.

You cannot request replacement cards using a HCF 10110 (formerly DES 3070) or CARES.

This page last updated in Release Number : 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

7.1.8 WAIVER OF MA BENEFIT LIMITATIONS

Someone who is eligible for MA but has been refused a specific MA benefit by the provider can be given a waiver. The waiver lifts the limitation and allows the client to receive the benefit.

The provider of the service must request the waiver. The request goes to the Division of Health Care Financing (DHCF).

This page last updated in Release Number: 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

7.1.9 THIRD PARTY COVERAGE

See Chapter 6.3

This page last updated in Release Number : 03-02
Release Date: 04/01/03
Effective Date: 04/01/03

7.2 GOOD FAITH CLAIMS

7.2.1 DEFINITION OF GOOD FAITH CLAIMS

A Good Faith claim is a claim that has been denied by Medicaid with an eligibility-related Explanation of Benefits (EOB) code. This occurs even though the provider verified eligibility for the dates of service billed and submitted a correct and complete claim. Providers can resubmit the claim to EDS to be processed as a Good Faith claim. If the eligibility file has been updated by the time the claim is resubmitted, it will be paid automatically. If the file still does not reflect eligibility for the period covered by the claim, EDS will try to resolve the eligibility discrepancy. If they are unable to resolve it from the information available, they will contact you to verify eligibility. The Good Faith form (HCF 10111) is used for this purpose. A Good Faith claim cannot be reimbursed until the EDS recipient file is updated.

This page last updated in Release Number: 01-02
Release Date: 04/01/01
Effective Date: 04/04/01

7.2.2 DENIALS

If a provider receives a claim denial for one of the following reasons on the Remittance Advice, the provider can resubmit it as a Good Faith claim .

R/A Report Denial Code	Reason
029	Medicaid number doesn't match recipient's last name.
172	Recipient Medicaid ID number not eligible for dates of service.
281	Recipient Medicaid ID number is incorrect. Verify and correct the MA number and resubmit claim.
614	MA number doesn't match recipient's first name.

This page last updated in Release Number : 01/02
Release Date : 04/01/01
Effective Date : 04/01/01

7.2.3 CAUSES AND RESOLUTIONS

Causes and A Good Faith claim can occur when:

1. A recipient presents an ID card that is invalid because:

   a. You issued a temporary ID card for a prior period or manually determined case and didn't update CARES or send EDS a to update the recipient's eligibility file. EDS will apply the dates of eligibility indicated on the card with med stat 71. A letter will be sent to you to confirm that the recipient is eligible for the dates on the card. The letter will include instructions on how to complete a (HCF 10111) and the information that is needed.

   b. The provider suspects the recipient of misusing or abusing a Medicaid ID card (i.e. using an altered card or a card that belongs to someone else). If the provider submits a copy of the card and EDS can tell that it was altered, EDS will contact you to verify the recipient was eligible or forward it to the Division of Health Care Financing (DHCF) for review.

2.

   The recipient's name has changed since the card was issued. EDS can usually resolve claims that are denied with code "029" and "614". If necessary, EDS will contact you to confirm the information.

With the implementation of the Forward ID cards, providers are less likely to receive one of the eligibility-related denials used for Good Faith claims submission. Providers are told to verify eligibility using the variety of methods available to them through the Eligibility Verification System (EVS). When the provider verifies the client's eligibility, they are getting the most current information available on the MMIS. Therefore, it is unlikely that they will be told the client is eligible when s/he is not.

The most likely reason a Good Faith situation arises is when a provider sees a temporary paper ID card issued by the agency. The provider may bill MA before the eligibility is updated on MMIS, or perhaps the eligibility was never sent to MMIS. In either case,if the client presents a valid temporary Medicaid ID card for the dates of service, and the provider sends a copy of the card with the Good Faith claim , EDS will update the client's eligibility file with a good faith segment and pay the claim immediately.

EDS will then attempt to resolve the discrepancy from information on file or contact you to confirm eligibility and correct the eligibility segment. If the provider doesn't send a copy of the ID card with the claim, EDS must confirm eligibility with you before the claim can be paid.

The definition of a 'valid' card is either a:

1. Forward card that indicates eligibility for the dates of service through the EVS.

2. A temporary paper card showing dates of eligibility.

This page last updated in Release Number : 01-02
Release Date :04/01/01
Effective Date : 04/01/01

7.2.4 PROCESS

EDS initiates the Good Faith claim process by sending you a Good Faith form (HCF 10111) that they have partially completed, and one or two letters, depending on what documentation of eligibility the provider included with their claim. Complete the (HCF 10111) form if this is a new client (cert. 1) or return a new HCF 10110 (formerly DES 3070) for amended certifications (cert. 3). Send completed (HCF 10111) forms to:

EDS
Good Faith Unit
P.O. Box 6215
Madison, WI 53784

Send completed 3070 forms to:

1. Mail: EDS
   P.O. Box 7636

Madison, WI 53707

2. E-mail: eds_3070@dhfs.state.wi.us

3. Fax: (608) 221-8815

This page last updated in Release Number : 02-03
Release Date : 01/01/02
Effective Date : 07/01/02

7.2.5 INSTRUCTIONS

Agency Denial
If the client identified on this Good Faith form was neither eligible nor possessed a valid ID card for the dates of service indicated in field six, place an "X" in this box. If you check "Yes" here, you must also check the reason in the field below.

Recipient Did Not Have ID Card After Date of Service
Place an "X "in this box if you are certain that the client did not possess a valid MA ID card for the date of service. In the blank provided, enter the closing date of eligibility.

Recipient Not Eligible
Place an "X" in this box if the client was not eligible for any of the dates of service shown. If the client was eligible for some of the dates of service, follow the instructions for completing the Partial Deny box.

Record Not Found
Place an "X" in this box if the client has never been eligible for MA in your agency.

Dates of Services
EDS enters the dates of service for the claim.

Partial Deny
Use this field only if the client had eligibility for some of the dates of service. Enter the "from" and "to" dates which cover the portion of the dates of service for which the client did not have eligibility.

Type of Certification
EDS will check one of these boxes:

1. Initial Certification
   EDS will place an "X" in this box when the client and MA number submitted on the claim cannot be found on the eligibility master file.

2. Amended Certification

EDS will place an “X” in this box when the client is on MMIS, but no eligibility exists for the claimed dates of service.

Agency Number
EDS will enter the three-digit code of the agency they believe may have certified the client during the dates in question.

Casehead ID Number
EDS will enter the known or suspected MMIS case number (primary person’s SSN + tie-breaker) of the client listed on the provider’s claim.

Action Date
EDS enters the date they completed the Good Faith form.

Medical Status Code
When EDS receives the provider’s claim along with a photocopy of an ID card, a hard copy response received through EVS or a transaction log number from the Automated Voice Response (AVR). EDS compares the dates of service with the dates on the card. If the dates of service fall within the dates of eligibility for the ID number on the card, EDS enters a “71” medical status code and pays the claim immediately. EDS then enters the eligibility dates for the entire month in which services were provided.

If the client was eligible for the entire period of certification shown on the Good Faith form (HCF 10111) , remove the “71” medical status code and write in the correct code. Attach a HCF 10110 (formerly DES 3070) to add the certification period and appropriate medical status code for the time when the client was eligible for MA.

Period of Certification
If EDS has entered the suspected period of certification to be added to the recipient master file, check it for accuracy. Then complete a HCF 10110 (formerly DES 3070) and enter the period of certification if the client file does not show eligibility for the time when the client was eligible or for the time covered by an ID card issued to the client.

Control Name Year of Birth
EDS will enter the suspected control name and year of birth (YOB) for the client. This control name must be the first four letters of the client’s last name. The YOB is the last two digits in the client’s year of birth. Both of these items must match the information currently in the client’s EDS file.

Current ID Number
EDS will enter the client’s current MA ID number.

Date of Birth
EDS completes this field only for initial certifications. Change this birth date if the date entered is incorrect. Indicate birthdate as MM/DD/CCYY.

Signature of Agency Director
Good Faith forms must have an authorized signature for initial certifications.

Worker ID
On initial certifications, enter the six-digit worker code of the certifying ES worker.

This page last updated in Release Number : 02-03
Release Date:07/01/02
Effective Date: 07/01/02

8 APPENDIX

8.1 TABLES

8.1.1 reserved

8.1.2 LIFE ESTATE AND REMAINDER INTEREST

Use the following process to determine a client's life estate/remainder interest.

1. Go to the IRS web-site http://www.irs.gov/businesses/small/article/0,,id=112482,00.html .

2. Look up the (Section 7520) interest rate for the month and year you are making the valuation. Make a note of the interest rate listed.

   For Example, the Section 7520 interest rate for October 2004 is 4.4%.

3. Go to the IRS web-site http://www.irs.gov/pub/irs-pdf/p1457.pdf Refer to the IRS Actuarial S (pages 13-112). Locate the interest rate for the month of valuation. (The interest rate you looked up in step 2)

   Note: The Adobe search function may assist you in finding the appropriate table. Type Table S in the search field and choose the appropriate interest rate from the search results.

   For Example the Appropriate table for the October 2004 interest rate, (4.4%) is found on page 24 of the PDF.

4. Find the applicable row for the age of the individual you are doing a valuation. Use the life estate/remainder interest listed in this row for the valuation.

This page last updated in Release Number: 05-01
Release Date: 01/11/05
Effective Date: 01/11/05

8.1.3 County & Tribe Area

Use this list to determine which column to use in the AFDC-related categorically needy income test.If a municipality is in 2 counties, use the area for the county in which the MA fiscal group resides. If a pregnant woman is in a maternity home, use the area in which the home is located, even though the county of residence making the payment is in the other area. For example, if her county of residence is Vilas (Area 2) and she is in a maternity home in Milwaukee (Area 1), Vilas county pays at the Area 1 rate.

8.1.3.1 Area 1

Brown	Kenosha	Outagamie	Sheboygan
Dane	La Crosse	Ozaukee	Washington
Dodge	Marathon	Racine	Waukesha
Dunn	Manitowoc	Rock	Winnebago
Eau Claire	Milwaukee	St. Croix	Winnebago Tribe*

8.1.3.2 Area 2

Adams
Ashland
Bad River
Barron
Bayfield
Buffalo
Calumet
Chippewa
Clark
Columbia
Crawford
Door
Douglas
Florence
Forest
Green
Iowa
Iron
Jackson
Jefferson
Juneau

Kewaunee
Lafayette
Langlade
Lincoln
Marinette
Marquette
Menominee
Monroe
Oconto
Oneida
Pepin
Pierce
Polk
Portage
Price
Richland
Rusk
Sauk
Sawyer
Shawano
Taylor
Trempeleau
Vernon
Vilas
Walworth
Washburn
Waupaca
Waushara

Lac Courte Oreilles
Lac du Flambeau
Menominee Tribe
Mole Lake
Potawatomi
Red Cliff
St.Croix Tribe
Stockbridge -Munsee
Winnebago Tribe

_

_*Only if residing on tax-free land in La Crosse or Marathon
_County. All other locations are Area 2.

8.1.4 AFDC-Related Income Table

Group Size	Categorically Needy		Medically Needy
	Area I	**Area II**	
1	$ 311	$ 301	$ 591.67
2	$ 550	$ 533	$ 591.67
3	$ 647	$ 626	$ 689.33
4	$ 772	$ 749	$ 822.67
5	$ 886	$ 861	$ 944.00
6	$ 958	$ 929	$1,021.33
7	$ 1,037	$ 1,007	$1,105.33
8	$ 1,099	$ 1,068	$1,172.00
9	$ 1,151	$ 1,117	$1,226.67
10	$ 1,179	$ 1,143	$1,257.33
11	$ 1,204	$1,168	$1,284.00
12	$1,229	$1,193	$1,310.67
13	$1,254	$1,218	$1,337.33
14	$1,279	$1,243	$1,364.00
15	$1,304	$1,268	$1,390.67
16	$1,329	$1,293	$1,417.33
17	$1,354	$1,318	$1,444.00
18	$1,379	$1,343	$1,470.67
+	+25 each person above 18	+25 each person above 18	+26.67 each person above 18

This page last updated in Release Number: 02-01
Release Date: 10/01/01
Effective Date: 10/01/01

8.1.5 Elderly, Blind, and Disabled (EBD) Assets & Income Table

Group Size		
Category	**1**	**2**
EBD Categorically Needy Limits	**Assets** _$2,000 **Income** _$469.78 (+ actual shelter up to $193.00)	**Assets** _$3,000 **Income** $711.38 (+ actual shelter up to $289.67)
EBD Medically Needy Limits	**Assets** _$2,000 **Income** _$591.67	**Assets** _$3,000 **Income** _$591.67
SSI Payment Level		
Federal SSI Payment Level	**Income**_$579.00	**Income**_$869.00

State Supplementary Payment (SSP)	**Income**	$ 83.78	**Income**_$132.05
TOTAL	**Income**_$662.78		**Income**_$1001.05
SSI Payment Level + E Supplement	**Income**_$758.77		
SSI E Supplement	**Income**_$95.99		
Community Waivers Special Income Limit	**Income**_$1,737.00		**Income** _
Institutions Categorically Needy Income Limit	_ **Income**_$1,737.00		

8.1.5.1 EBD Deductions and Allowances

	Description		**Amount**
1	Personal Needs Allowance (effective 7/1/01)		$45.00
2	Personal Needs Allowance for PACE/partnership participants who reside in a CBRF		$65.00
3	EBD Maximum Personal Maintenance Allowance		$1737.00
3	EBD Deeming Amount to an Ineligible Minor		$289.50
4	Community Waivers Basic Needs Allowance		$759.00
5	Parental Living Allowance for	**1 Parent**	$579.00
	Disabled Minors	**2 Parent**	$869.00
6	MAPP Standard Living Allowance (SLA) SLA = SSI + State Supplement + $20		$682.00

This page last updated in Release Number: 05-01
Release Date: 01/11/05
Effective Date: 01/01/05

8.1.6 FPL Table

Group size	100% FPL	120% FPL	133% FPL	135% FPL	150% FPL	185% FPL	200% FPL	250% FPL
1	$775.83	$931.00	$1,031.86	$1047.38	$1,163.75	$1435.29	$1,551.67	$1,939.58
2	$1040.83	$1,249.00	$1,384.31	$1,405.13	$1,561.25	$1,925.54	$2,081.67	$2,602.08
3	$1,305.83	$1,567.00	$1,736.76	$1762.88	$1,958.75	$2,415.79	$2,611.67	$3,264.58
4	$1,570.83	$1,885.00	$2,089.21	$2,120.63	$2,356.25	$2,906.04	$3,141.67	$3,927.08
5	$1,835.83	$2,203.00	$2,441.66	$2,478.38	$2,753.75	$3,396.29	$3,671.67	$4,589.58
6	$2,100.83	$2,521.00	$2,974.11	$2,836.13	$3,151.25	$3,886.54	$4,201.67	$5,252.08
7	$2,365.83	$2,839.00	$3,146.56	$3,193.88	$3,548.75	$4,376.79	$4,731.67	$5,914.58
8	$2,630.83	$3,157.00	$3,499.01	$3,551.63	$3,946.25	$4,867.04	$5,261.67	$6,577.08
9	$2,895.83	$3,475.00	$3,851.46	$3,909.38	$4,343.75	$5,357.29	$5,791.67	$7,239.58
10	$3,160.83	$3,793.00	$4,203.91	$4,267.13	$4,741.25	$5,847.54	$6,321.67	$7,902.08
11	$3,425.83	$4,111.00	$4,556.36	$4,624.88	$5,138.75	$6,337.79	$6,851.67	$8,564.58
12	$3,690.83	$4,429.00	$4,908.81	$4,982.63	$5,536.25	$6,828.04	$7,381.67	$9,227.08
13	$3,955.83	$4,747.00	$5,261.26	$5,340.38	$5,933.75	$7,318.29	$7,911.67	$9,889.58
14	$4,220.83	$5,065.00	$5,613.71	$5,698.13	$6,331.25	$7,808.54	$8,441.67	$10,552.08
15	$4,485.83	$5,383.00	$5,966.16	$6,055.88	$6,728.75	$8,298.79	$8,971.67	$11,214.58
16	$4,750.83	$5,701.00	$6,318.61	$6,413.63	$7,126.25	$8,789.04	$9,501.67	$11,877.08
each additional person	$265.00	$318.00	$352.45	$357.75	$397.50	$490.25	$530.00	$662.50
	• Kids 6 Through 18 • QMB	• SLMB	• Cat Needy Pregnant Women • PE • kids <6	• SLMB+	• BC premium limit • MAPP premium limit	• Med Needy Pregnant Women • PE • kids <6 • BC applicant premium limit • FPW	• QDWI • BC recipient limit	• MAPP

This page last updated in Release Number: 04-03
Release Date: 08/02/04
Effective Date: 03/01/04

8.1.7 COLA

To calculate the Cost-of-Living Adjustment (COLA) disregard amount, do the following:

1. Find the AG's current gross Old Age Survivors Disability Insurance (OASDI) income. The gross OASDI income is the amount of the OASDI check **plus** any amount that has been withheld for a Medicare premium **plus** any amount with-held to repay an earlier overpayment. Do not include in the gross income any Medicare Plan B premiums which the State has purchased for the AG.

2. On the COLA Disregard Amount Table below find the last month in which the person was eligible for and received a check for both OASDI and Supplemental Security Income (SSI).

3. Find the decimal figure that applies to this month.

4. Multiply the person's current gross OASDI income by the applicable decimal figure. The result is the COLA disregard amount.

COLA Disregard Amount Table

January -December 2005	0.02629
January -December 2004	.046317
January -December 2003	0.059485
January - December 2002	0.083318
January - December 2001	0.114317
January - December 2000	0.135076
January - December 1999	0.146175
January - December 1998	0.163737
January - December 1997	0.187305
January - December 1996	0.2079
January - December 1995	0.229474
January -December 1994	0.249
January -December 1993	0.270874
January -December 1992	0.296889
January -December 1991	0.332912
January -December 1990	0.362858
January -December 1989	0.387363
January -December 1988	0.412057
January -December 1987	0.419602
January -December 1986	0.437053
January -December 1985	0.45609
January -December 1984	0.474483
July 1983-December 1983	0.510692
July 1982- June 1983	0.559975
July 1981-June 1982	0.615026
July 1980-June 1981	0.649705

July 1979-June 1980	0.671085
July 1978-June 1979	0.68941
July 1977-June 1978	0.708092
July 1976-June 1977	0.729715

This page last updated in Release Number: 05-01
Release Date: 01/11/05
Effective Date: 01/01/05

8.1.8 Reserved

8.1.9 Hospital Daily Rates

City	Hospital Name	Average IP Daily Charge Based on Gross Inpatient Revenue*
Amery	Amery Regional Medical Center	2,089.80
Antigo	Langlade Memorial Hospital	2,138.75
Appleton	Appleton Medical Center	2,619.86
Appleton	St. Elizabeth Hospital	2,116.37
Arcadia	Franciscan Skemp Healthcare-Arcadia	3,092.15
Ashland	Memorial Medical Center, Inc.	1,482.73
Baldwin	Baldwin Area Medical Center, Inc.	2,533.16
Baraboo	St. Clare Hospital and Health Services	2,179.26
Barron	Barron Medical Center, Mayo Health System	1,954.05
Beaver Dam	Beaver Dam Community Hospitals, Inc.	2,668.64
Beloit	Beloit Memorial Hospital, Inc.	2,372.91
Berlin	Berlin Memorial Hospital	2,281.50
Black River Falls	Black River Memorial Hospital	2,008.27
Bloomer	Bloomer Medical Center, Mayo Health System, Inc.	2,650.71
Boscobel	Boscobel Area Health Care	2,223.16
Brookfield	Elmbrook Memorial Hospital	2,939.91
Burlington	Memorial Hospital Corporation of Burlington	3,388.85
Chilton	Calumet Medical Center, Inc.	2,275.09
Chippewa Falls	St. Joseph's Hospital	1,328.26
Columbus	Columbus Community	2,189.11

	Hospital, Inc.	
Cumberland	Cumberland Memorial Hospital and ECU	1,401.31
Darlington	Memorial Hospital of Lafayette County	2,176.27
Dodgeville	Upland Hills Health	2,319.07
Durand	Chippewa Valley Hospital	4,079.93
Eagle River	Eagle River Memorial Hospital, Inc.	2,089.94
Eau Claire	Luther Hospital	2,856.90
Eau Claire	Sacred Heart Hospital	2,048.11
Edgerton	Memorial Community Hospital	4,277.41
Elkhorn	Lakeland Medical Center, Inc.	2,818.54
Fond du Lac	Agnesian HealthCare, Inc.	2,038.43
Fond Du Lac	Fond du Lac County Department of Com. Prog.	542.75
Fort Atkinson	Fort Atkinson Memorial Health Services	1,611.49
Friendship	Adams County Memorial Hospital	2,122.78
Grantsburg	Burnett Medical Center, Inc.	2,463.85
Green Bay	Bellin Memorial Hospital	3,203.79
Green Bay	Bellin Psychiatric Center	1,127.78
Green Bay	Brown County Mental Health Center	604.30
Green Bay	Libertas Treatment Center	599.69
Green Bay	St. Mary's Hospital Medical Center	2,150.08
Green Bay	St. Vincent Hospital	2,181.42
Greenfield	Kindred Hospital-Milwaukee	2,863.08
Hartford	Aurora Medical Center	1,951.60
Hayward	Hayward Area Memorial Hospital	2,499.17
Hillsboro	St. Joseph's Comm. Health Services, Inc.	3,214.87
Hudson	Hudson Hospital	3,123.36

Janesville	Mercy Health System Corporation	2,959.12
Janesville	Rock County Psychiatric Hospital	627.07
Kenosha	Aurora Medical Center - Kenosha	3,394.71
Kenosha	Children's Hospital of WI, Inc. - Kenosha	1,583.90
Kenosha	Kenosha Hospital and Medical Center	3,002.25
La Crosse	Franciscan Skemp Healthcare - La Crosse	2,472.35
La Crosse	Gundersen Lutheran Medical Center, Inc.	3,399.28
Ladysmith	Rusk Co. Memorial Hospital and Nursing Home	1,713.81
Lancaster	Grant Regional Health Center, Inc.	2,827.16
Madison	Mendota Mental Health Institute	577.84
Madison	Meriter Hospital, Inc.	2,740.11
Madison	St. Mary’s Hospital Medical Center	2,785.67
Madison	University of WI Hospital and Clinics Authority	3,171.65
Manitowoc	Holy Family Memorial Medical Center	2,349.37
Marinette	Bay Area Medical Center	1,985.82
Marshfield	Norwood Health Center	662.10
Marshfield	Saint Joseph's Hospital	2,693.24
Mauston	Hess Memorial Hospital	2,500.85
Medford	Memorial Health Center, Inc.	2,079.43
Menomonee Falls	Community Memorial Hospital	2,527.08
Menomonie	Myrtle Werth Hospital-Mayo Health System	2,020.15
Mequon	St. Mary's Hospital-Ozaukee	2,626.39
Merrill	Good Samaritan Health Center	1,862.32
Milwaukee	Aurora Sinai Medical Center	3,504.31

Milwaukee	Children's Hospital of Wisconsin	4,109.72
Milwaukee	Columbia Hospital, Inc.	3,142.63
Milwaukee	Froedtert Memorial Lutheran Hospital	3,763.75
Milwaukee	Milwaukee County Mental Health Complex	658.69
Milwaukee	Sacred Heart Rehabilitation Institute	1,590.18
Milwaukee	St. Joseph's Hospital	2,870.63
Milwaukee	St. Luke's Medical Center	4,194.60
Milwaukee	St. Mary's Hospital-Milwaukee	3,038.61
Milwaukee	St. Michael Hospital	3,041.39
Monroe	The Monroe Clinic	2,821.34
Neenah	Theda Clark Medical Center	2,123.14
Neillsville	Memorial Hospital, Inc	2,546.27
New London	New London Family Medical Center	2,048.86
New Richmond	Holy Family Hospital	2,331.20
Oconomowoc	Oconomowoc Memorial Hospital	2,756.58
Oconomowoc	Rogers Memorial Hospital	845.81
Oconto	Oconto Memorial Hospital, Inc.	2,419.99
Oconto Falls	Community Memorial Hospital	2,436.47
Osceola	Osceola Medical Center	2,533.79
Oshkosh	Mercy Medical Center of Oshkosh	2,204.91
Osseo	Osseo Area Hospital and Nursing Home, Inc.	8,485.86
Park Falls	Flambeau Hospital, Inc.	2,149.84
Platteville	Southwest Health Center, Inc.	2,053.36
Portage	Divine Savior Healthcare	2,096.57
Prairie Du Chien	Prairie du Chien Memorial Hospital	2,986.91
Prairie Du Sac	Sauk Prairie Memorial Hospital	2,575.36
Racine	All Saints-St. Luke's Hospital, Inc.	1,500.18

Racine	All Saints-St. Mary's Medical Center, Inc.	2,203.06
Reedsburg	Reedsburg Area Medical Center	2,252.02
Rhinelander	Saint Mary's Hospital, Inc.	2,601.07
Rice Lake	Lakeview Medical Center	1,649.24
Richland Center	The Richland Hospital, Inc.	2,376.05
Ripon	Ripon Medical Center	2,345.92
River Falls	River Falls Area Hospital	2,771.15
Shawano	Shawano Medical Center	1,945.56
Sheboygan	Sheboygan Memorial/Valley View Medical Center	2,414.85
Sheboygan	St. Nicholas Hospital	1,870.69
Shell Lake	Indianhead Medical Center Shell Lake, Inc.	1,889.70
Sparta	Franciscan Skemp Healthcare-Sparta	2,503.34
Spooner	Spooner Health System	2,063.49
St. Croix Falls	St. Croix Regional Medical Center, Inc.	2,738.80
Stanley	Victory Medical Center	2,768.09
Stevens Point	Saint Michael's Hospital	2,016.21
Stoughton	Stoughton Hospital Association	1,945.35
Sturgeon Bay	Door County Memorial Hospital	3,027.83
Superior	St. Mary's Hospital of Superior	1,959.67
Tomah	Tomah Memorial Hospital, Inc.	1,660.85
Tomahawk	Sacred Heart Hospital, Inc.	1,350.84
Two Rivers	Aurora Medical Center of Manitowoc City, Inc.	2,441.01
Viroqua	Vernon Memorial Hospital	2,196.89
Waterford	Lakeview NeuroRehab Center Midwest	1,655.79
Watertown	Watertown Memorial Hospital	2,476.15

Waukesha	Waukesha County Mental Health Center	694.85
Waukesha	Waukesha Memorial Hospital, Inc.	2,691.44
Waupaca	Riverside Medical Center	1,958.61
Waupun	Waupun Memorial Hospital	1,903.18
Wausau	North Central Health Care Facilities	694.88
Wausau	Wausau Hospital	2,602.82
Wauwatosa	Aurora Psychiatric Hospital	1,075.72
West Allis	Rogers Memorial Hospital - Milwaukee	1,674.72
West Allis	Select Specialty Hospital	2,372.35
West Allis	West Allis Memorial Hospital	3,282.94
West Bend	St. Joseph's Community Hospital	1,758.48
Whitehall	Tri-County Memorial Hospital, Inc.	2,472.95
Wild Rose	Wild Rose Community Memorial Hospital Inc.	2,077.47
Winnebago	Winnebago Mental Health Institute	457.54
Wisconsin Rapids	Riverview Hospital Association	1,934.27
Woodruff	Howard Young Medical Center, Inc.	2,509.65

Data Source: Gross Inpatient Revenue and Total Discharge Days, 2001 Wisconsin Hospital Fiscal Survey

* Average Daily Charge is the sum of Gross Inpatient Revenue and Gross Inpatient Ancillary Revenue divided by Total Discharge Days.

This page last updated in Release Number: 03-01
Release Date: 01/01/03
Effective Date: 01/01/03

8.1.10 Life Expectancy Table

male age at annuity/trust settlement option	male projected life expectancy	female age at annuity/trust settlement option	female projected life expectancy
0	71	0	76
1	71	1	76
2	71	2	76
3	71	3	76
4	71	4	76
5	71	5	76
6	71	6	76
7	72	7	76
8	72	8	76
9	72	9	76
10	72	10	76
11	72	11	76
12	72	12	77
13	72	13	77
14	72	14	77
15	72	15	77
16	72	16	77
17	72	17	77
18	72	18	77
19	72	19	77
20	73	20	77
21	73	21	77
22	73	22	77
23	73	23	77
24	73	24	77
25	73	25	78
26	73	26	78
27	73	27	78
28	73	28	78
29	73	29	78
30	73	30	78
31	73	31	78
32	73	32	78
33	73	33	78
34	74	34	78
35	74	35	78
36	74	36	78
37	74	37	78
38	74	38	78

39	74	39	79
40	74	40	79
41	74	41	79
42	75	42	79
43	75	43	79
44	75	44	79
45	75	45	79
46	75	46	79
47	75	47	80
48	76	48	80
49	76	49	80
50	76	50	80
51	76	51	80
52	76	52	80
53	77	53	81
54	77	54	81
55	77	55	81
56	77	56	81
57	78	57	81
58	78	58	82
59	78	59	82
60	79	60	82
61	79	61	82
62	79	62	83
63	80	63	83
64	80	64	83
65	80	65	84
66	81	66	84
67	81	67	84
68	82	68	85
69	82	69	85
70	83	70	85
71	83	71	86
72	83	72	86
73	84	73	87
74	85	74	87
75	85	75	88
76	86	76	88
77	86	77	88
78	87	78	89
79	87	79	90
80	88	80	90
81	89	81	91
82	89	82	91
83	90	83	92
84	90	84	92

85	91	85	93
86	92	86	94
87	93	87	94
88	93	88	95
89	94	89	95
90	95	90	96
91	95	91	97
92	96	92	98
93	97	93	98
94	98	94	99
95	99	95	100
96	99	96	100
97	100	97	101
98	101	98	102
99	102	99	103
100	103	100	104
101	103	101	104
102	104	102	105
103	105	103	106
104	106	104	107
105	107	105	108
106	107	106	108
107	108	107	109
108	109	108	110
109	110	109	111
110	111	110	112
111	111	111	112
112	112	112	113
113	113	113	114
114	114	114	115
115	115	115	116

This page last updated in Release Number: 94-01
Release Date: 01/01/94
Effective Date: 10/01/93

8.1.11 BadgerCare Premiums

BadgerCare Premiums- Income exceeds 150% of the FPL

From	To	Premium
$1,000	$1,499.99	$50
$1,500	$1,999.99	$75
$2,000	$2,499.99	$100
$2,500	$2,999.99	$125
$3,000	$3,499.99	$150
$3,500	$3,999.99	$175
$4,000	$4,499.99	$200
$4,500	$4,999.99	$225
$5,000	$5,499.99	$ 250
$5,500	$5,999.99	$ 275
$6,000	$6,499.99	$ 300
$6,500	$6,999.99	$ 325
$7,000	$7,499.99	$ 350
$7,500	$7,999.99	$ 375
$8,000	$8,499.99	$ 400
$8,500	$8,999.99	$ 425
$9,000	$9,499.99	$ 450
$9,500	$9,999.99	$ 475
$10,000	$10,499.99	$ 500

This page last updated in Release Number: 04-01
Release Date: 2/27/04
Effective Date: 01/01/04

8.1.12 FC Deductions and Allowances

	Description	Amount
1	**Basic Asset Allowance**	
	• Nursing Home (NH), Community Based Residential facility (CBRF), or Adult Family Home (AFH) Disregard)	$9,000.00
	• Residential Care Apartment Complex (RCAC or other community setting disregard	$12,000.00
2	**Basic Needs Allowance**	
	Nursing Home (NH), Community Based Residential facility (CBRF), or Adult Family Home (AFH)	$65.00
3	**Projected Cost of Care**	
	• Comprehensive or Comprehensive Nursing Home Level of Care	$3307.00
	• Grandfather or Intermediate Level of Care	$637.00

This page last updated in Release Number: 01-05
Release Date: 10/10/01
Effective Date: 10/10/01

8.1.13 MApp premiums

MAPP Premiums - Income exceeds 150% of the FPL

MAPP PREMIUM SCHEDULE

Sum of Adjusted Countable Unearned and Adjusted Earned Income		The premium is:	Sum of Adjusted Countable Unearned and Adjusted Earned Income		The premium is:
From	To	PREMIUM	From	To	PREMIUM
$0	$25.00	$0.00	500.01	525.00	500.00
25.01	50.00	25.00	550.01	575.00	550.00
50.01	75.00	50.00	575.01	600.00	575.00
75.01	100.00	75.00	600.01	625.00	600.00
100.01	125.00	100.00	625.01	650.00	625.00
125.01	150.00	125.00	650.01	675.00	650.00
150.01	175.00	150.00	675.01	700.00	675.00
175.01	200.00	175.00	700.01	725.00	700.00
200.01	225.00	200.00	725.01	750.00	725.00
225.01	250.00	225.00	750.01	775.00	750.00
250.01	275.00	250.00	775.01	800.00	775.00
275.01	300.00	275.00	800.01	825.00	800.00
300.01	325.00	300.00	825.01	850.00	825.00
325.01	350.00	325.00	850.01	875.00	850.00
350.01	375.00	350.00	875.01	900.00	875.00
375.01	400.00	375.00	900.01	925.00	900.00
400.01	425.00	400.00	925.01	950.00	925.00
425.01	450.00	425.00	950.01	975.00	950.00
450.01	475.00	450.00	975.01	1000.00	975.00
475.01	500.00	475.00	1000.01	1025.00	1000.00

If the subtotal from the MAPP Premium Calculation Worksheet is more than $1,025 a month, the premium is equal to the exact whole dollar amount of the subtotal.

This page last updated in Release Number: 02-01
Release Date: 01/01/02
Effective Date: 01/01/02

8.1.14 seniorcare income limits

See 5.16.7

This page last updated in Release Number: 04-03
Release Date: 07/01/04
Effective Date: 03/01/04

8.2 WORKSHEETS

8.2.1 Worksheets table of contents

Following is a list of Medicaid worksheets. All worksheets should be copied for your use.

_

WORKSHEETS NUMBER	NAME
Wkst 01	Medicaid Non-Financial
Wkst 02	Dependent Care
Wkst 03	Medicaid Deductible
Wkst 04	Medicaid Institution Determination
Wkst 05	Medicaid Extensions
Wkst 06	EBD – Related Determination Worksheet
Wkst 07	Spousal Impoverishment Income Allocation
Wkst 08	Medicaid Purchase Plan (MAPP) Eligibility
Wkst 09	Medicaid Purchase Plan (MAPP) Premium Calculation
Wkst 10	Medicaid Purchase Plan (MAPP) Work Expenses
Wkst 11	Medicaid Purchase Plan (MAPP) Medicaid/Remedial Expenses
Wkst 12	Family Care Eligibility – Non-MA Financial Determination
Wkst 13	FFU Income
Wkst 14	AFDC-Related Determination Worksheet

This page last updated in Release Number: 04-02
Release Date: 07/01/03
Effective Date: 07/01/03

8.3 FORMS

8.3.1 Forms

All DHFS forms and publications are found in numerical order by form number at http://dhfs.wisconsin.gov/em/numerical-list.htm

All DHFS Medicaid forms are found in alphabetical order by form name at http://dhfs.wisconsin.gov/em/formslist.htm

All DHFS Medicaid publications are found in alphabetical order by publication name at
http://dhfs.wisconsin.gov/em/pubslist.htm

This page last updated in Release Number: 04-02
Release Date: 07/01/03
Effective Date: 07/01/03

Glossary

AFDC-MA

AFDC-MA is the category of Medicaid that is based on rules for the Aid to Families with Dependant Children Program (AFDC) that were in effect on July 16, 1996.

CAF

Combined Application Form

CARES

Client Assistance for Re-employment & Economic Support

Cascade

The MA cascade is the hierarchy of eligibility.

COLA

Cost of Living Adjustment

COP

Community Options Program

DAC

Disabled Adult Child

ICF

Intermediate Care Facility

IMD

Institute for Mental Disease

Income

Income is anything you receive in cash or in kind that you can use to meet your needs for food, clothing, and shelter.

Liquid Assets

Liquid assets are defined as cash or assets which can readily be converted to cash. Examples include: bank accounts (savings or checking); postal savings; credit union or building and loan shares; contents of safe deposit boxes; savings bonds; stocks and other securities; promissory notes and mortgages which are payable to the applicant/recipient and negotiable; etc.

MAPP

The Medicaid Purchase Plan (MAPP) offers people with disabilities who are working or interested in working the opportunity to obtain health care coverage through the Wisconsin Medicaid Program.

Non-legally responsible relative (NLRR)

A non-legally responsible relative (NLRR) caretaker is a caretaker who has no legal responsibility for the minor or 18 year-old under his/her care.

INDEX

1

3

5

A

D

E

F

G

H

K

L

M

N

O

P

Q

R

S

U

V

W